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RESTRICTIVE TRADE PRACTICES COMMISSION

T.R.C. 24
HEARINGS RELATED TO THE MANUFACTURE, DISTRIBUTION
AND SALE OF DRUGS

HEARINGS HELD AT TORONTO

VOLUME 21-23

OCTOBER 25, 26 and 27, 1961

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Professor H.J. Fuller



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6	President, Jules R. Gilbert Limited	2820
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13	T-18 (Vol. 21)	Intra-Office Study of Canadian Pharmaceutical Journal
14	T-19	Copy of Jules R. Gilbert Drug Catalogue, 1959
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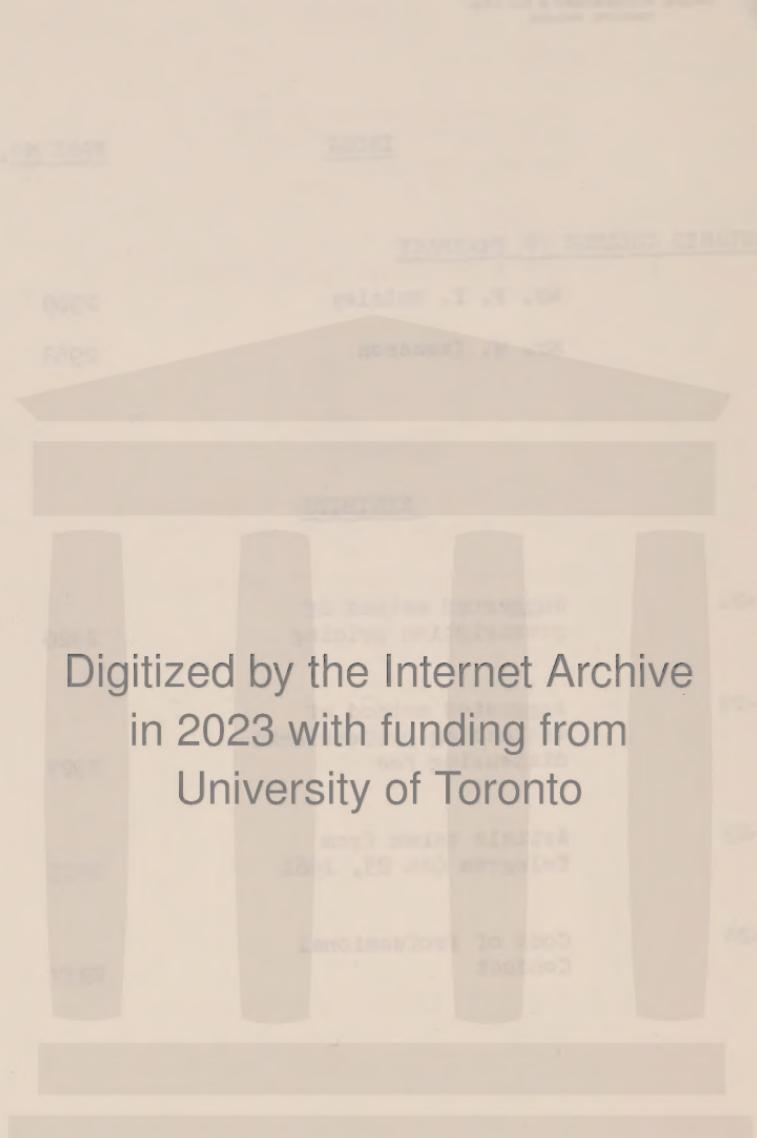
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3 INQUIRY UNDER SECTION 42

4 OF THE COMBINES INVESTIGATION ACT

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Relating to the manufacture, distribution and sale
of drugs

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COMMISSION:

13

C. RHODES SMITH, Q.C. -- Chairman

14

A.S. WHITELEY, M.A. Member of the
Commission

15

PIERRE CARIGNAN, Q.C. Member of the
Commission

16

F.N. MACLEOD Combines Officer,
representing the Director of Investigation
and Research

17

18

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Proceedings of hearings commencing at
10 a.m., Wednesday, October 25th, 1961,
et seq in the City of Toronto, in the
Province of Ontario.

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Toronto, Ontario,
October 25th, 1961.

--- On commencing at 10 a.m.

THE CHAIRMAN: Mr. Turnbull, will you continue.

MR. TURNBULL: Mr. Chairman, members of the Commission, if we may for a moment revert to yesterday's discussion at the bottom of page 60 and at the top of page 61 in which we commented relative to the net profit based on sales of a retail pharmacy. We have looked into this and have come to the conclusion that the sentence itself is very poorly constructed. It does not convey our basic thinking in this matter, and we have not had time to check further into the possibility of coming up with the figure suggested by the Commission yesterday.

With your permission we would like to have
this sentence deleted from our presentation.

THE CHAIRMAN: That is the last line on page 60 and the first line on page 61?

MR. TURNBULL: Yes, the line which reads,
"In the light of current investment returns and interest
rates on borrowed money, a 5% net profit for a retail
pharmacy is indeed slim".

Then, turning to page 62 in the table which appears thereon, the figures have now all been checked. Regrettably we picked the one line in which errors appeared. Professor Fuller advises me that in line 3 in the category \$1.01 to \$1.50, it should read:

Delete 90¢ to read 80¢

Delete 45¢ to read 55¢

Delete \$1.36 to read \$1.46



1 Then the final column will read \$2.55 in place of \$2.45.

2 THE CHAIRMAN: The 59.5% remains?

3 MR. TURNBULL: That 59.5% has been double-
4 checked and that is correct.

5 THE CHAIRMAN: With all those changes, it
6 could be.

7 MR. TURNBULL: Basically, the two that are
8 affected are the 90¢ and the 45¢, and the amendment, 80¢
9 and 55¢ is correct. All the other figures in this table
10 have been checked since we adjourned yesterday and found
11 to be properly recorded.

12 One further point in our discussion yester-
13 day, there was some discussion relative to returned goods
14 privileges and the Chairman asked about broken quantities.
15 We have no figures on this matter. In general, manufac-
16 turers do not accept broken quantities for return. One
17 of my colleagues with me today has indicated the possibi-
18 lity of some 20% of broken quantity packages which are
19 over one-year old will be written off.

20 One further point relative to what we
21 defined as a prescription drug. The prescription drug is
22 any drug, be it legislatively restricted to prescription
23 only sale or not, which is used in the compounding or
24 dispensing of a prescription and which is part of an
25 overall pharmaceutical service.

26 THE CHAIRMAN: Does that mean that any drug
27 which is commonly sold over the counter with no restric-
28 tions attached to it at all, in a particular case where
29 it is prescribed, it would be a prescription drug in that
30 case?



1 MR. TURNBULL: Yes sir.

2 Continuing on page 81 of our presentation:

3 Prescription Prices:

4 There are possibly only two basic questions
5 that are foremost in the minds of those to whom pharmaceu-
6 tical services are rendered and of those who are confronted
7 with the task of economic reviews:

8 1. "The average price per prescription has
9 increased over the years. Why?"

10 2. "The ratio of prescription revenue to
11 gross sales in retail pharmacies has
12 increased over the years. Why?"

13 These questions are best answered in outline format and
14 require little explanatory writing, in that the points are
15 generally recognized by all who have taken cognizance of
16 economic changes in our country over the past few decades.

17 1. "The average price per prescription has increased over
18 the years. Why?"

19 (a) Inflation in Consumer Price Index

20 (b) Inflation in wage rates

21 (c) Quantity within each prescription has
22 increased

23 (d) Cost of ingredients - the newer, higher
24 priced drugs have increased while making
25 available specific medication, as opposed to
26 the less specific symptomatic treatment of
27 two decades ago;

28 Federal sales tax on ingredients increased
29 from 8% to 11% between 1951 and 1958

30 (e) More chronic, ambulatory treatment with



1 a concentration of specific disease cate-
2 gories in hospitals

3 (f) Remuneration of persons who render
4 professional services has increased

5 (g) Physicians and patients, alike, expect
6 more from drug therapy than in the past,
7 with a consequent concentration on this
8 aspect of health services.

9 THE CHAIRMAN: I am just wondering why the
10 last one would mean that the average price has gone up.
11 Do you mean that people use more prescription drugs, but
12 does that have any effect on the average price?

13 MR. TURNBULL: A higher utilization of the
14 newer proportion is what we are referring to here.

15 THE CHAIRMAN: Oh yes, of more expensive
16 drugs.

17 MR. TURNBULL: 2. "The ratio of prescrip-
18 tion revenue to gross sales in retail pharmacies has
19 increased over the years. Why?"

20 (a) More prescriptions dispensed

21 (b) The average prescription price has
22 increased

23 (c) Traditional non-prescription sales are
24 now shared more with other outlets such as
25 supermarkets, thus proportionately lowering
26 the gross sales of retail pharmacies

27 (d) The ratio of population per pharmacy
28 has increased

29 (e) Greater urban population with resultant
30 urban convenience, as opposed to rural



1 accessibility to pharmacies and other health
2 care facilities

3 (f) More health dollars available as a conse-
4 quence of various health insurance schemes

5 (g) A generally improved standard of living
6 and health, and a desire to maintain same

7 In the following pages there are several
8 references made to a bibliography which is included at
9 the close of the section on page 92. You may possibly
10 wish to go through this, sir, and come back on questions,
11 in that quite a number of the figures are related to one
12 another, or could come up again in subsequent sections,
13 whatever you wish.

14 THE CHAIRMAN: I am sure my colleagues and
15 I have read the pages.

16 There is one point mentioned in the general
17 picture presented here that I would like to ask about.
18 That is, have you made any survey to ascertain the number
19 of people who have had this prescription in any one or
20 several of these years?

You show the per capita cost across the country. It is in total only a very small percentage of people who have had occasion to have prescription drugs. The picture would not be very clear because what makes people complain about it is the cost that affects them.

26 MR. TURNBULL: That is correct.

27 THE CHAIRMAN: An individual cost might be
28 very high if it is only a few dollars per capita in the
29 country, and I was just wondering if you had some informa-
30 tion on that.



1 MR. TURNBULL: We would have liked to have
2 been able to present such information, but regrettably
3 there is no known source of such information in Canada at
4 the moment.

5 This is one of the matters that we have
6 stressed to the Royal Commission on Health Services, the
7 Hall Commission, as being a piece of vital information to
8 its work, and we hope to work very closely with the Hall
9 Commission in determining just that fact. There have
10 been some figures rather loosely used. I don't think
11 that I can competently quote them.

12 THE CHAIRMAN: No.

13 MR. TURNBULL: But we do recognize this
14 very fact. Do you wish me to proceed with the reading of
15 this?

16 THE CHAIRMAN: As far as I am concerned, and
17 I think my colleagues agree, I don't think it is necessary
18 to go into all these lists of figures and totals that are
19 here. What is said is quite clearly expressed.

20 I would think we might take this as read,
21 and we can have it written into the record, and if there
22 are questions arising out of it subsequently from any
23 source during the hearing, there will be a point of refe-
24 rence in the transcript.

25 Members of the Commission who have points to
26 raise or others who have questions on that aspect, perhaps
27 we might deal with those now.

28 An Examination of the Cost of Prescription Services

29 At the onset it should be noted that the
30 figures developed in this section relate to prescription



1 medication through retail pharmacies in Canada and do not
2 apply to the total Canadian market for these pharmaceuticals.
3 The Canadian Pharmaceutical Manufacturers' Association recently estimated that in 1960, at the manufacturer's
4 level, sales to retail pharmacies represent approximately
5 62.5% of the total market of its member-companies. Of the
6 remaining 37.5% of their sales, about 2/3 are to hospitals
7 and the remaining 1/3 to governments and other institutions.
8 (1) (A bibliography is included at the close of
9 this section).

11 1960 DATA

12 Gross National Product \$ 35,959,000,000.00
13 Personal Income \$ 27,442,000,000.00
14 Personal Disposable Income \$ 25,084,000,000.00
15 Personal Disposable Income spent
16 on Consumer Goods and Services \$ 23,409,000,000.00 (2)
17 Spent in Retail Stores \$ 16,413,465,000.00
18 Spent in Drug Stores \$ 408,655,000.00 (3)
19 Personal Expenditures on Prescribed Medicine in 1960 were
20 25% of pharmacy receipts (4)
21 . . 1960 Personal Expenditures on
22 Prescribed Medicines in Retail
23 Pharmacies \$ 102,163,750.00
24 Population in Canada in 1960 -- 17,814,000 (5)
25 . . the per capita expenditure on prescribed medicine in
26 Canada through retail pharmacies in 1960 may be esti-
27 mated as \$5.73.
28 The Canadian Pharmaceutical Association's 19th Annual
29 Survey of Retail Pharmacy Operations would give somewhat
30 higher results.

1960 DATA

2 Total Sales in Retail Pharmacies \$ 524,371,520.00

3 Total Receipts - Prescribed

4 Medicines \$ 131,092,880.00

5 . . per capita expenditure on prescribed medicine in
6 Canada through retail pharmacies in 1960 may be
7 estimated as \$7.36 for 2.4 Prescriptions. (6)8 Historical Trend in Costs9 The ten year growth in the number of pres-
10 creptions dispensed, their total value and the average
11 cost per prescription is set out in the following table:

12 (7)

13 Year	14 Total Number of Prescriptions	15 Total Value of Prescriptions	16 Average Prescription Price
1951	30,958,675	\$ 52,010,574.00	\$ 1.68
1952	31,453,240	57,244,896.00	1.82
1953	31,798,456	64,277,248.00	2.07
1954	30,115,818	68,664,067.00	2.28
1955	32,908,185	74,372,498.00	2.26
1956	35,102,361	87,404,881.00	2.49
1957	40,036,416	103,230,236.00	2.61
1958	40,445,325	112,438,004.00	2.78
1959	43,916,605	130,871,483.00	2.98
1960	42,840,810	131,092,880.00	3.06

24 It can be seen from examination of the above
25 table that in the ten year period, 1951 - 1960, a 38.4%
26 increase in the total number of prescriptions dispensed
27 and an 82.1% increase in the average prescription price
28 have combined to produce a 152.1% increase in the total
29 value of all prescriptions dispensed in retail pharmacies



1 in this country.

2 This apparently large increase in total
3 value deserves a more detailed examination of the most
4 important of the factors which have contributed to this
5 increase.

6 1. General Economic Factors: (a) Population Expansion:

Year	Population of Canada	Per Capita Cost of Prescriptions	Average Prescription Price	Average number of Prescriptions per capita
1951	14,009,429	\$ 3.71	\$ 1.68	2.21
1960	17,814,000 (8)	7.36	3.06	2.41

11 The growth in population has, then, contributed very extensively to the upward trend in total prescription value in Canada. Although the total value of prescriptions has increased by 152.1% in the ten year period from 1951 to 1960, inclusive, the per capita cost of prescriptions has shown a less dramatic increase in the same period, of 98.4%. The average prescription price has increased 82.1% in the same period, while the average number of prescriptions, per capita, increased by 9.5%.

19 (b) Inflationary Trend of Consumer Price Index

Year	Yearly Per Capita Cost of Prescriptions	Consumer Price Index (1949 = 100)	Per Capita Yearly Cost of Prescriptions in Constant 1949 Dollars	Average Prescription Price in Constant 1949 Dollars	Average Prescription Price in 1949 Dollars
1951	\$ 3.71	113.7	\$ 3.26	\$ 1.68	\$ 1.48
1960	7.36	128.0 (9)	5.75	3.06	2.39

26 Thus, the per capita expenditure on prescription drugs in Canada in 'constant dollars' has shown an
27 increase of 76.4% in the cited ten year period. The
28 average prescription price in 1949 dollars has increased
29 only 61.5% in the same period.



(c) Upward Trend in Wage Rates

However, wages in Canada have risen at a
than the Consumer Price Index.

Year	Per Capita Index Num-	Real per capita Pres-	Average Pres-	Real Average Pres-
Cost of Prescrip-	ber of Weekly Wages in Pres-	cost of Pres-criptions	Price in 1949 Dol-	Price in 1949 Dol-
tions in Constant 1949 Dol-	1949 Dollars (10)	in 1949	1949 Dol-	1949 Dol-
1949 Dol-				
lars		Dollars	lars	

On elimination of economic factors, it can
be seen that the real per capita cost of prescriptions in
Canada has increased only 34.7% in the ten year period
studied. The real average prescription price has increased
by 22.9%.

15 It is, therefore, generally conceded that
16 the increase in the real per capita cost of prescriptions
17 in constant dollars (34.7% in the period studied) is
18 largely the result of:

- (i) the increase in the average number of prescriptions per capita, per year, of 9.5%
 - (ii) the increase in the real average prescription price in constant dollars (1949), of 22.9%

24 2. Factors Affecting the Real Per Capita Cost of Prescrip-

25 tions in Constant Dollars in Canada

(a) Factors Affecting Increased Utilization

(i) Trend to Urbanization

Population of incorporated cities and towns
has been growing more rapidly than has
Canadian population in general. (11)



	<u>Population of Incorporated Cities and Towns</u>	<u>Percent of Total Population</u>
1951	7,941,222	56.68%
1956	9,286,121	57.75%

The D.B.S. "City Family Expenditure, 1957"
examined the expenses of 1,088 families in 9 cities
across Canada: (12)

Average Family Prescription Outlay in 1957 \$ 27.70

Average Family Size 3.4 persons

. . . average per capita prescription expense

for 1957 \$ 8.15

Total population in 1957 was 16,589,000 (13)
while total value of prescriptions was \$103,230,236.00 (14)
giving an average per capita expenditure on prescriptions
of \$6.22.

These figures, therefore, suggest that urban
persons spend more on prescriptions than do their non-
urban counterparts.

This would be linked to availability of
pharmaceutical services, and generally, other health
service facilities, to a great extent. The total popula-
tion figures used include Eskimos, Indians and other per-
sons inhabiting remote sections of the country who have
little or no access to a retail pharmacy.

It is, then, clear that urban residents
expend more on prescription medication and, therefore, the
trend to urbanization has had a definite buoyant effect on
the level of utilization of prescription services in the
retail pharmacies of the country.

1 (ii) Number of Retail Pharmacies

2 The number of retail pharmacies in Canada
3 has increased from 4,071 (1 for every 3,441
4 persons) in 1951 to 4,915 (1 for every
5 3,624 persons) in 1960. (15)

6 Although the increase in the number of phar-
7 macies during this period did not keep pace
8 with the increase in population, the abso-
9 lute increase of 844 (or 20.7%) would have
10 made pharmaceutical services better available
11 in communities that had previously been
12 lacking in those facilities.

13 This increase in availability would, in turn,
14 have had an upward effect on the level of
15 utilization of prescription services through
16 retail pharmacies.

17 (iii) Age of the Population

18 The Canada Year Book 1960 states, "A high
19 birth rate together with a low death rate
20 among children added, between 1951 and 1956,
21 nearly 1,000,000 to the population under 15
22 years of age and raised the proportion of
23 this group to the total population from
24 30.3% to 32.5%." (16)

25 In this same six year period, persons over 75
26 years of age increased by 21.2% (from
27 337,704 to 409,117), while the total popula-
28 tion increased by only 14.8% (from 14,009,429
29 to 16,080,791) in the same period. (17)
30 The two cited population trends suggest that



the age groups of under 15 years and over 75 years are increasing at a rate which is in excess of overall population expansion and are, therefore, becoming a larger proportion of total population.

New medications have played a large role in decreasing infant mortality and in increasing the life span. Moreover, elderly persons with a high incidence of chronic and debilitating diseases and children with a high incidence of childhood communicable diseases are the age groups that make most frequent use of medication. The "Statistics of Medical Services for Public Assistance Beneficiaries, Saskatchewan, 1959 - 1960" reveals that the 'over 70' age group within the Saskatchewan scheme received 8.8 prescriptions per capita per year. This figure is almost four times the average for the total population of Canada of 2.41 prescriptions per capita per year.

(iv) Number of Physicians in Canada

Year	Number of Physicians in Canada	Population	Number of Population per Physician
1953	15,500		
1954	15,650		
1955	16,150		
1956	16,571	16,080,791	970.4
1957	17,419		
1958	18,975		



Year	Number of Physicians in Canada	Population of Canada	Number of Population per Physician
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1959	19,844		
------	--------	--	--

1960	20,200 (18)	17,814,000 (19)	881.9
------	-------------	-----------------	-------

In the five year period from 1956 to 1960, the number of physicians in Canada increased by 3,629 (or 21.9%), while the total population of Canada increased by 1,733,209 (or 10.8%). Thus, in 1956, there was one physician for every 970.4 persons in Canada, while in 1960, only five years later, there was one physician for every 881.9 persons. The fact that physicians' services are more accessible to the population would tend to increase the number of prescriptions received by the population.

"Medical Economics" in June, 1956, stated, "the average American physician wrote 95 more prescriptions in 1955 than he did in 1954". We suggest that this has been a continuing trend and one which has been manifest in Canada, as well.

(v) Increased Confidence in Efficacy of Drugs
A great portion of the new tools available to the modern physician are in the form of new and better medicinal agents. It is estimated that 45% of the drugs prescribed today could not have been provided five years ago because they did not exist. Among these drugs are the tranquilizers which have



produced such dramatic results in the
mentally ill; many new antibiotics which
have rendered cures of many previously
feared infectious diseases commonplace;
new drugs to combat hypertension and heart
disease. The list is long.

The development of more specific medicinals
with the concurrent development of more
specific understanding of their use by the
medical profession has increased the confi-
dence in these agents by the physicians of
Canada. This, in turn, has had a buoyant
effect on the frequency of prescribing.

Drug therapy of the ambulatory patient has
reduced the incidence of home and hospital
bed care relative to many illnesses.

The public, too, have become increasingly
aware of the role played by the newer drugs
in alleviating pain, effecting a cure,
relieving uncomfortable symptoms, and often
saving a life. Drug names such as penicil-
lin, aureomycin, chloromycetin, seconal,
nembutal, cortisone and codeine have become
household terms. Therapeutics group termi-
nology such as tranquilizers, sedatives,
analgesics, antibiotics and amphetamines
are commonly mouthed, although not very
clearly understood by persons with no connec-
tion to any of the health professions.

Indeed, physicians now are often asked for



1 a prescription for either a specific drug or
2 a drug of a specified therapeutic group.
3 Articles in consumer magazines all too often
4 glamourize certain effects especially of
5 new drugs. We do not condone such often
6 misinformed pressure on a physician to pres-
7 cribe. This relatively recent phenomenon is
8 cited only as an indication of the increasing
9 public confidence in newer medications which
10 has, in turn, led to increasing public accep-
11 tance of the theory and practice of prescri-
12 bing.

13 (b) Factors Affecting the Increase in the
14 Real Average Prescription Price

15 (i) The Number of Doses in the Average Pres-
16 cription

17 Due to the increasing public familiarity with
18 the newer drugs, and since many of these
19 newer medications have been developed for the
20 treatment of continuing chronic ailments, we
21 suspect that the average prescription of today
22 contains more doses for use over a longer
23 period of time than did the average prescrip-
24 tion of a decade ago. Unfortunately, to our
25 knowledge, no reliable data are available.

26 (ii) The Cost of Ingredients

27 The method of pricing prescriptions in Canada
28 has traditionally been on the basis of manu-
29 facturer's suggested retail price plus a
30 nominal dispensing fee.



1 The trend in the average prescription price
2 to rise is a direct indication that the
3 cost of the ingredients of this average
4 prescription have also been rising. The
5 ingredients of the 'average' prescription
6 are not a specific combination of drugs,
7 but rather reflect the mass of new medici-
8 nals which are introduced to the market
9 every year and which are often more expen-
10 sive to the retail pharmacist.

11 Historically, the price of a specific drug
12 has declined after its introduction when
13 mass production, distribution and markets
14 have been attained. The economies thus
15 realized have been passed on to the retail
16 pharmacist and, through him, to the general
17 public.

18 The extent to which the rising ingredient
19 cost has added to the average prescription
20 price is difficult to determine. No total
21 ingredient costing exists which would corres-
22 pond to the total receipts from prescriptions
23 as determined by the C.Ph.A.'s survey. Also,
24 no information is available to relate the
25 date and area fluctuations in the dispensing
26 fee charged for prescriptions.



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(iii) The Cost of Professional Pharmaceutical Service

Year	Average Sales of Retail Pharmacies Current \$	Average Total Expenses of Retail Pharma- cies Current \$	Total Expenses as a Percent- age of Sales	Average Manager's Salary plus em- ployees' wages Current \$	Manager's Salaries plus Wages as a percent of Sal-
1952	\$ 63,601.00	\$ 14,514.00	22.8	\$ 9,120.00	14.3
1953	77,235.00	20,179.00	26.1	13,007.00	16.8
1954	76,448.00	20,259.00	26.5	12,958.00	16.9
1955	70,009.00	21,672.00	27.5	14,020.00	17.8
1956	83,650.00	23,087.00	27.6	15,057.00	18.0
1957	92,903.00	25,428.00	27.4	16,612.00	18.0
1958	90,270.00	27,417.00	27.9	17,688.00	18.0
1959	103,079.00	28,062.00	28.0	18,555.00	18.0
1960	106,688.00	30,300.00	28.4	19,417.00	18.2 (20)

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The table above shows that in the nine year period from 1952 to 1960, while the average yearly sales in retail pharmacies have increased 67.7%, the average total expenses of the same stores have increased at the more rapid rate of 108.8%. Expenses as a percentage of total sales have thus risen to 28.4% in 1960 from 22.8%, nine years earlier (a 5.6% larger portion of the sales dollar). Wages, as a percentage of sales, have increased from 14.3% in 1952 to 18.2% in 1960 (or 3.9% more) of the sales dollar. Wages have been the largest single factor contributing to a more rapid increase in expenses than in sales. Over the years, trading discounts have



1 remained relatively stable and have, thus,
2 assumed a relatively constant proportion of
3 normal overall operating business costs of
4 the retail pharmacy.

5 The increase in the cost of wages of persons
6 who provide professional pharmaceutical
7 service is responsible for the fluctuations
8 which have taken place, over the years, in
9 the amount of the professional dispensing
10 fee charged on the individual prescription
11 service.

12 In 1960, the average pharmacy in the C.Ph.A.
13 Survey dispensed 8,846 prescriptions. (21)
14 Dispensing fees increases have only partially
15 filled the gap left by rising costs of phar-
16 maceutical services. Higher frequency of
17 prescribing and higher absolute dollar return
18 from prescriptions have partially filled the
19 residual portion of this spread. Higher
20 absolute dollar return, referred to above,
21 results from the stable percentage markup
22 applied to higher cost ingredients.

23 (iv) Federal Sales Tax

24 From May of 1936 to May of 1951, this tax
25 remained at the level of 8%. In May of
26 1951, the tax was raised to 10%, and in
27 April of 1959 was again raised to 11%.

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- 7 (6) C.Ph.A., 19th Annual Survey of Retail Pharmacy Opera-
- 8 tions 1960
- 9 (7) ibid
- 10 (8) D.B.S., Canadian Statistical Review
- 11 (9) D.B.S., Prices and Price Indexes, December 1960, page
- 12 20
- 13 (10) ibid, page 27
- 14 (11) Canada Year Book 1960, page 180
- 15 (12) D.B.S., City Family Expenditure 1957
- 16 (13) Canada Year Book 1960, page 1260
- 17 (14) C.Ph.A., 19th Annual Survey of Retail Pharmacy Opera-
- 18 tions 1960
- 19 (15) As quoted by Registrars of Provincial Statutory Bodies
- 20 at December 31 of each year
- 21 (16) Canada Year Book 1960, page 188
- 22 (17) ibid
- 23 (18) Canadian Medical Directories, Toronto, Telephone
- 24 Quotation, August 1, 1961
- 25 (19) Canada Year Book 1960, page 1261
- 26 (20) C.Ph.A. Surveys of Retail Pharmacy Operations, Surveys
- 27 12 to 19
- 28 (21) C.Ph.A. 19th Annual Survey of Retail Pharmacy Opera-
- 29 tions 1960
- 30



/EMT/hm 1 MR. WHITELEY: On page 85, under (c), the
2 final column there is real average prescription price in
3 1949 dollars. By what is the dollar value of prescriptions
4 deflated for the figures in that column?

5 MR. TURNBULL: You mean percentagewise?

6 MR. WHITELEY: I mean what is the deflationary
7 factor you used to get these figures?

8 MR. TURNBULL: Well, item (c) leads on from
9 item (b), in which item (b) first of all refers to the
10 consumer price index, and (c) an extension of that, using
11 similar D.B.S. tables, based on wage rate trends in D.B.S.
12 tables. Item number 10. That is the price indices of
13 December 1960, extending the table presented under (b)
14 into (c) rather than skipping straight from the yearly per
15 capita cost of prescriptions right through to the final
16 point.

17 MR. WHITELEY: In (b), it is a common system
18 of procedure to use this to arrive at constant dollar value,
19 but to use your wage rate or index of wages itself as a
20 factor, I do not think that is so common. I assume your
21 final column there is really meant to be in 1949 wage dollars,
22 is it?

23 MR. TURNBULL: That is correct.

24 MR. WHITELEY: I mean the entire population
25 of Canada is not remunerated on the basis of those wage
26 rates. Only a certain portion of the populace gets its
27 income in that way?

28 MR. TURNBULL: That is right.

29 MR. WHITELEY: And other elements of the
30 population may have differing trends in their remuneration.



1 MR. TURNBULL: I believe, sir, that is
2 readily acknowledged, not only by ourselves, but also by
3 the D.B.S., even when they are figuring on consumer price
4 indicies relative to the national level.

5 MR. WHITELEY: You go on to draw certain
6 conclusions that the real per capita cost has increased
7 only 34.7%.

8 MR. TURNBULL: Yes.

9 MR. WHITELEY: I presume that would only
10 apply to those that are in receipt of those wages?

11 MR. TURNBULL: That is correct.

12 MR. WHITELEY: What happens to the rest of
13 the population is not indicated by this comparison.

14 MR. TURNBULL: Actually in a second, if I
15 may, Mr. Chairman, I would ask my associate secretary, Mr.
16 Ross, to comment on this. Mr. Ross is head of our economics.

17 Basically I think it should be realized and
18 appreciated that regrettably average figures and average
19 extensions are the only things that are available, and as
20 such figures might be made available to us and to others
21 of the population by the Dominion Bureau of Statistics,
22 we have used these with no attempt to bring these figures
23 into local levels or provincial levels or into wage dis-
24 crepancy levels.

25 MR. WHITELEY: Another section of the
26 population is the farm population, and there are figures
27 as to farm income. You could use that as a basis of
28 comparison. It might not be the same as this.

29 MR. TURNBULL: Yes, sir, we could.

30 MR. WHITELEY: So that to interpret this as



1 the real per capita cost seems to be extending beyond
2 legitimate scope.

3 MR. TURNBULL: It is my understanding that
4 the terminology of "real", which possibly should be put in
5 a single quote or a double quote, is not an unusual term
6 for, in effect, the basic figure. May I ask Mr. Ross....

7 MR. ROSS: Mr. Chairman, and Mr. Whiteley,
8 we are of course dealing with averages in this section.
9 The index from weekly wages in 1949 dollars that we have
10 used is the average for the total population.

11 As Mr. Whiteley says we could have equally
12 as well done it for average farm income, or we could have
13 done it for average industrial wage, but not wishing to
14 burden the thing too much, we tried to do it this way since
15 all the figures before this section have dealt with the
16 Dominion averages, then we have just extended this one step
17 further. In effect, by removing the inflationary trend
18 of consumer price index as is done in section (b), this al-
19 lows for inflationary trends, but does not reflect increase
20 in the standard of living resulting from the fact wages
21 have increased at a higher rate than has the consumer
22 price index. So, in effect, by taking this greater increase
23 in wage rates into consideration, all we were doing
24 in this last column, the real average prescription price,
25 for instance, we are saying in effect that it takes the
26 average worker in Canada 22.9% longer to earn the price of
27 the average prescription. The real per capita cost of
28 prescriptions in 1949 dollars, we are in effect saying that
29 it takes the average Canadian worker 34.7% longer to earn
30 this per capita cost.



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3 This is all that is intended, but unfortunately
4 we did not do it for industrial wage, but as I say, we
5 have just extended our average figures that we have used
6 up to this time one step further.

7 THE CHAIRMAN: It is confined to wage
8 earnings. This second step. What Mr. Whiteley is saying,
9 if you are considering average costs for Canadians as a
10 whole, wage earners are only one group in a community.

11 MR. ROSS: That is quite true.

12 THE CHAIRMAN: Likewise the farm population
13 is a large and important group, and if we can believe what
14 the farm leaders tell us, their income has gone down rather
15 than up. If that is the fact, then it would cost them
16 more. Average costs might be noticeably above the figure
17 you have quoted for wage earners?

18 MR. ROSS: All we are trying to say is for
19 the wage earner, it would take him this much longer to
20 earn the average prescription or price, or earn the per
21 capita cost, the yearly per capita cost.

22 THE CHAIRMAN: This applies only to wage
23 earnings?

24 MR. ROSS: Just to wage earnings, that is
25 correct.

26 MR. WHITELEY: I am not sure that your last
27 statement is correct. If you are going to have an increase
28 in the standard of living, then the amount of effort put
29 forth to procure an article must go down rather than up.
30 If it goes up, your standard of living is going to go down.



1 MR. ROSS: When I talk about the increase
2 in the standard of living, I am thinking on a broad
3 basis of all products. We realize by saying these things
4 we are in effect admitting that the standard of living as
5 applied to prescription drugs has not decreased because
6 of the greater number of higher priced drugs that are
7 appearing on the market.

8 THE CHAIRMAN: You said has not decreased.
9 You mean it has not increased?

10 MR. ROSS: It has not increased, if the one
11 factor were used. This is what in effect we are trying to
12 show, that regardless of increase in the standard of
13 living it is still costing Canadians this much more for
14 prescriptions in terms of time worked to pay for these.

15 THE CHAIRMAN: The standard of living has
16 still gone up because they are buying much more?

17 MR. ROSS: That is quite true. The content
18 of the average prescription has changed dramatically, but
19 as I say, all we can deal with is averages I am afraid.

20 THE CHAIRMAN: If a person buys three times
21 as much of one type of product in 1961 as compared to
22 1950, even though the cost is somewhat more, and this is
23 three times as much you might say, the standard of living
24 as regard to these things has improved.

25 MR. ROSS: Oh, yes. We attempted to develop
26 this in the next section.

27 MR. TURNBULL: Do you want me to read on
28 from there?

29 THE CHAIRMAN: I think as far as I am
30 concerned, I won't ask you to read this. I think my



1 colleagues are satisfied. That takes you to page 92,
2 does it?

3 MR. TURNBULL: With regard to that question
4 you asked earlier, Mr. Chairman, we have placed some
5 figures at the lower part of page 87 concerning the over
6 70 age group, but this of course is only one part of the
7 whole picture. We discussed elderly persons with a high
8 incidence of chronic and debilitating diseases, and
9 children with a high incidence of childhood communicable
10 diseases which are the age groups that make most frequent
11 use of medication.

12 Then figures from the Statistics of
13 Medical Services for public assistance beneficiaries,
14 Saskatchewan, 1959 to 1960, reveals that the over 70 age
15 group within the Saskatchewan scheme received 8.8 pres-
16 ciptions per capita per year. This figure is almost four
17 times the so-called average for the total population of
18 Canada of 2.41 prescriptions per capita per year.

19 THE CHAIRMAN: It still doesn't deal with
20 the point I raised as to what percentage of those over 70
21 get any prescriptions.

22 MR. TURNBULL: That is correct.

23 THE CHAIRMAN: This material goes to the
24 end of page 92, I think you said.

25 MR. TURNBULL: Yes, sir.

26 THE CHAIRMAN: You might proceed from there.

27 -

28 -

29 -

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R/hm

1

MR. TURNBULL:

2 Prescription Volume - Price Relationship

3 In its hearings across Canada, this Commission
4 has suggested that a relationship should exist between
5 the volume of prescription services performed in a single
6 outlet and the cost of each of these services to the general
7 public.

8 THE CHAIRMAN: They don't know the Commission
9 suggested that should be the case but they indicated it
10 might very well be the case, that a man who had a large
11 volume, if he wanted to increase his business might do
12 what they do in other lines of business: Reduce his price
13 a little bit and perhaps gain something in the long run.
14 That may not work in the pharmaceutical business but it
15 appears to work in other industries.

16 MR. TURNBULL: This line of reasoning tends
17 to imply that the allocation of professional manpower
18 existing in those retail pharmacies of Canada which perform
19 a smaller volume of individual prescription services,
20 raises the price of each service to the population.
21 Conversely, this reasoning could imply that retail outlets
22 which have a greater proportion of their receipts from
23 such services could, or even should, reduce the price of
24 each service to the public. The Association questions the
25 soundness of such a line of reasoning. A relationship be-
26 tween volume of services and price of each service does
27 not, and properly cannot, exist.

28 While it is readily admitted that the pro-
29 fessional capacities of pharmacists to dispense prescriptions
30 are less fully utilized in many community pharmacies, it is



1 emphasized by the pharmacists of Canada that this situation
2 does not add to the price that the public assumes for each
3 service.

4 It would be a misconception of economic
5 facts to regard the prescription department of the retail
6 pharmacy in isolation from the total store operation. When
7 the proportion of prescription revenue to total sales
8 decreases, sales of prescription accessories, as well as
9 associated and sundry merchandise must increase in
10 proportion to total sales.

11 These other sales are largely profitable
12 and without them the pharmacy doing minimal volume in
13 prescriptions could not exist. They do, in fact, subsi-
14 dize the operation of the prescription department in many
15 cases. Let us take, for example, a pharmacy which dis-
16 penses a volume of 10 prescriptions a day, seven days a
17 week.

18 And possibly our example of 10 is not too
19 good but we are using a low figure to dramatize the situation.
20 The average prescription price for 1960, reported in
21 the 19th Annual C.Ph.A. Survey of Retail Pharmacy, was
22 \$3.06. Therefore, the pharmacy dispensing 10 prescriptions
23 a day has average daily prescriptions receipts of \$30.60.
24 Estimating that the average cost of ingredients
25 approximates 50% of gross prescription revenue, this sample
26 pharmacy would realize a gross profit on prescriptions of
27 \$15.30 per day. From this \$15.30 per day (\$5,635. per
28 year), overhead expenses must be paid before there will
29 be realized any proprietor's salary, salary of any
30 employed pharmacist, profit and return on capital invested



1 in inventory and fixtures. This sample, using the figure
2 of 10, is probably low, but from it, it is obvious that
3 prescription services rendered by many community pharma-
4 cies must be subsidized by other sales income. As
5 prescription receipts become a larger proportion of total
6 receipts, this essential subsidization decreases and
7 eventually disappears. The point remains that in minimal
8 dispensing pharmacies, when the pharmacist is not engaged
9 in dispensing prescriptions or other less tangible duties
10 associated with pharmaceutical services, his time is
11 occupied with selling activities, the proceeds of which
12 make it possible for him to provide prescription services
13 to his community at minimum cost which would otherwise
14 be impossible due to his net financial loss.

15 If the minimal operator finds it necessary
16 to subsidize his prescription department, does it follow
17 that the pharmacist with a larger proportion of his
18 receipts from prescriptions could reduce his prices for
19 these services when they are a more important portion of
20 his receipts? We think not. The C.Ph.A. Survey shows
21 that total expenses grow with prescription volume. (27.9%
22 of sales volume in stores with prescription receipts 10%
23 to 20% of total receipts --- and 31.9% of sales volume in
24 stores with prescription receipts over 40% of total receipts
25 --- a difference of 4% of gross volume.) If each retail
26 pharmacy priced prescriptions based on all actual costs and
27 reasonable profit, this would not lower the prices charged
28 by large dispensing stores, but would, we believe, increase
29 the prices required by minimal dispensing stores very
30 appreciably.



1 THE CHAIRMAN: Does this paragraph mean,
2 in your submission, that gross margin on prescription is
3 lower than the average gross margin of all other products?

4 MR. TURNBULL: No sir.

5 THE CHAIRMAN: I was just wondering if
6 this increase in the percentage of cost to sales -- you
7 have got 27.9% of sales volume in stores with prescription
8 receipts 10 to 20% of total receipts, and 31.9% of sales
9 volume in stores with prescription receipts over 40% --
10 that would seem to indicate something of the kind.

11 MR. TURNBULL: The relationship in general,
12 generally viewed would be determined pretty well by the
13 salaries and wages paid and the types of stores doing this
14 volume prescription business.

15 The higher per cent, or higher number of
16 pharmacists employed in the stores which are doing a
17 larger per cent of prescriptions, in the consequence would
18 have wages at a higher level.

19 At the same time, of course, the stores
20 with possibly a small volume do have somewhat higher costs
21 in the purchase of their -- could have a somewhat higher
22 cost in the purchase of their supplies because possibly
23 they are buying from more local sources but this is offset
24 by -- in the survey -- particularly in the wages and
25 salaries facilities picture.

26 THE CHAIRMAN: It seemed to me that in
27 comparing quite a small store the argument might run
28 differently, where you have only one salaried pharmacist.

29 MR. TURNBULL: Yes.

30 THE CHAIRMAN: Who devotes, because of the



1 small prescription business, a very small part of his
2 time to prescription work and a large part of his time to
3 selling other things because on selling the other matters
4 would be higher in that situation than in the case where
5 you have a fairly large store with a number of -- where he
6 is on a lower scale of wages selling non-prescriptions.

7 MR. TURNBULL: Yes, that is not incorrect.
8 You would have your higher salaried personnel where more
9 prescriptions are being dispensed and I think it shows up
10 in a table, possibly table 16 where salaries at the 10%
11 to 20% or at the 17% mark are noted, whereas salaries and
12 wages in the 30 to 40, or in the over 40 are at 20.6%
13 mark and have an almost 4% differential there.

14 THE CHAIRMAN: I was just a little bit
15 puzzled by the data here because it would seem to me where
16 you have a large store you should have a particularly
17 economical use of your highly paid staff.

18 MR. TURNBULL: Yes.

19 THE CHAIRMAN: Than you have in a small
20 operation where your highly paid staff also does the kind
21 of work for which the larger store would employ lower paid
22 help.

23 MR. TURNBULL: Regrettably the small opera-
24 tion must, of course, have a pharmacist on duty at all
25 times the pharmacy is open.

26 THE CHAIRMAN: Quite so.

27 MR. TURNBULL: But I think it should be
28 considered too that quite often in smaller establishments
29 there may not be any other pharmacist other than the owner-
30 manager. The owner-manager is assuming all of that and the



1 only other personnel you have will be unskilled or non-
2 professional employees.

3 THE CHAIRMAN: In your figures I have been
4 under the impression that you showed a salary, included
5 a salary for the proprietor?

6 MR. TURNBULL: Yes.

7 THE CHAIRMAN: So that it would be the same,
8 in that respect, as if he had employed a pharmacist?

9 MR. TURNBULL: Yes.

10 THE CHAIRMAN: He would be the highly paid
11 help spending a relatively small portion of his time on
12 prescription work and a little bit larger part of his time
13 on other activities.

14 MR. TURNBULL: These figures are extracted
15 right from the survey in which they have actually been
16 brought to our attention in that regard.

17 As a matter of fact, it has been viewed
18 in some writings that this queer situation continues to
19 exist where, in spite of the increase in the number of
20 prescriptions being filled daily, or over a yearly period,
21 a consequent net profit does not increase in keeping with
22 the expected increase that has been achieved.

23 MR. WHITELEY: I wonder if that general
24 conclusion can be drawn with respect to net profit? Just
25 examining these tables casually it appears to me that net
26 profit does increase as the portion of prescription business
27 rises.

28 MR. TURNBULL: We, of course, are not
29 referring here to net profit. We are making reference to
30 total expenses in this statement. I believe that later on



1 net profits are referred to but this paragraph is dealing
2 only with the fact that the total expenses grow as pres-
3 cription volume grows -- the ratio of prescription volume.

4 MR. WHITELEY: I thought you commented that
5 net profit did not grow.

6 MR. TURNBULL: I say the figures -- increasing
7 expenses, they appear to increase.

8 THE CHAIRMAN: They increase as the pres-
9 cription portion of the business increases in proportion
10 to the total?

11 MR. TURNBULL: Yes. Those figures used
12 here -- that are being used here.

13 THE CHAIRMAN: I am not sure that it does
14 have any relation to the probability of business as a
15 whole.

16 MR. TURNBULL: We are not making a reference
17 to that at the present time.

18 THE CHAIRMAN: I think I see how that is
19 arrived at. At first I was somewhat puzzled as to how it
20 would work out. When it is stated in those terms, I think
21 we understand.

22 MR. TURNBULL: Paragraph 122 of the Director's
23 Statement in reference to Table XIII, page 75, states:
24 "..... there was a decrease in total expenses as prescription
25 sales increased sufficient to make the total income of
26 the pharmacies selling a higher proportion of prescriptions
27 greater than that of pharmacies selling an average of
28 fewer prescriptions."

29 This statement incorrectly implies that
30 total expenses decline as the proportion of prescription



1 volume increases. Table XII in the Director's Statement
2 shows that pharmacies with prescription receipts 10% to
3 20% of total receipts have total expenses of 29.0% of sales,
4 while pharmacies with prescription receipts over 40% of
5 total receipts have total expenses of 31.1% of total sales.
6 Thus, total expenses climbed from 29.0% to 31.1% of total
7 sales - an increase of 2.1% of sales.

8 The total that the Director has used was of
9 1959 data. The same table covering operations in 1960
10 points up, even more dramatically, the increase in expenses
11 as prescriptions become a more important component of total
12 sales --- expenses increase from 27.9% to 31.9%, an
13 increase of 4.0% of sales.

14 And that is, of course, a repeat of the
15 figures used previously.

16 There is, too, evidence of misunderstanding
17 of the nature of a 'prescription service'. A prescription
18 is not an article of commerce. It is not wholesaled or
19 merchandised; the patient cannot trade it or resell it
20 for use by another. After dispensing, the prescription is
21 as personally oriented to the patient as is his own
22 signature.

23 A prescription drug is the tangible part of
24 a prescription service performed by a pharmacist for the
25 individual patient. The commodity involved, in the form
26 of a drug or mixture of medicinal agents, is only part of
27 the complete professional service --- a personal service
28 performed separately and precisely for each recipient.
29 It does not, then, follow that this service is of less
30 monetary value to a patient if it is performed by a



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1 pharmacist who has the opportunity of performing a
2 significant number of broadly similar services for other
3 recipients.

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D/PB/hm

1 MR. TURNBULL: If a physician has a large
2 number of patients, or if a lawyer has a large number of
3 clients, are these men, then, not simply considered
4 successful, in a business sense, at least, in their
5 respective fields of endeavour? Do we expect the physician
6 with many patients, or the lawyer with many clients to
7 place lowering values on his services because he is better
8 utilizing his professional resources and time and can
9 spread his overhead farther? No, certainly not. Should
10 the pharmacist charge less for his professional services
11 in instances where he has the opportunity of performing
12 many such separate services? The slightly greater gross
13 remuneration received by the pharmacist who has been able
14 to build up a larger prescription practice is his due
15 reward for the public respect he has attained, and for
16 successful business achievement within his profession.

17 Between the services rendered by the
18 profession of Pharmacy and by other professions, dis-
19 tinction~~s~~ are too often drawn by reference to the commodity
20 which is an integral part of the pharmacist's professional
21 service. Such comparisons concern a matter of degree,
22 only, in that the commodity supplied by the pharmacist
23 is responsible for a larger proportion of the final price
24 of the service. This very fact makes it more difficult
25 for a pharmacist to lower the price of his service with a
26 higher volume than it would be for members of other
27 professions, since the pharmacist assumes a large variable
28 cost per service than do other professional groups.

29 MR. WHITELEY: I am not sure I follow this
30 last one.



1 MR.TURNBULL: Basically, sir, where there
2 is a substantial proportion of the services involved as
3 a tangible item that has a basic price on it as opposed
4 to the services rendered by the members of other professions
5 where any tangible product is very minor there is that
6 large cost involved within the overall service and that
7 cost itself may vary.

8 MR. WHITELEY: Presumably it would offer
9 more scope for change. There would be a greater possibility
10 with this variation, it would appear to provide greater
11 opportunity for differences in price.

12 MR. TURNBULL: It is more difficult for a
13 pharmacist to lower price on his service with a higher
14 volume of his service.

15 MR. WHITELEY: He might keep his professional
16 fee standard?

17 MR. TURNBULL: That is correct.

18 MR. WHITELEY: If there is variation in
19 ingredient cost that might then make it easier to have a
20 change in a prescription price.

21 MR. TURNBULL: We don't think so.

22 MR. WHITELEY: That is the point. That is
23 what I am trying to clear up, why that isn't because the
24 fact it is such a large cost, it seems it would work in
25 that direction rather than against it.

26 MR. TURNBULL: That is the part that must
27 be recovered first to, shall we say, keep the lights on.

28 MR. WHITELEY: You are suggesting the cost
29 might vary?

30 MR.TURNBULL: It has a relationship to the



1 tangible part of the service or the overall pharmaceutical
2 service. -- The tangible part bears a definite relation-
3 ship to the overhead and other cost of the business practice
4 opposed to the professional fee for services.

5 MR. WHITELEY: I thought you were suggesting
6 that the cost might vary between different purveyors of
7 the quantity.

8 MR. TURNBULL: Not necessarily.

9 MR. WHITELEY: But I thought that was your
10 suggestion.

11 MR. TURNBULL: No.

12 THE CHAIRMAN: There is a suggestion in some
13 of the material we have had that a pharmacist performs
14 services and also sells goods and the suggestion is that
15 includes the drugs sold on a prescription. That is there
16 are two parts to it, to the pharmacist's function. You
17 indicate you regard the whole of his activity in regard
18 to prescriptions as a service and not part of it being
19 the sale of a product?

20 MR. TURNBULL: No, but we do recognize that
21 a considerable portion of the service is a tangible item.

22 THE CHAIRMAN: Oh yes, it is a different
23 way of putting it. It is the sale of a tangible article.
24 The way it has been put to us in some of the material we
25 have had, insofar as the product is concerned if there was
an increase in the volume the pharmacist might do what
some other merchants do reduce their margin on the article
sold because their increasing volume still gives them
profit and the reduction tends to increase their sales.

30 What would be your position on that?



1 MR. TURNBULL: Were you thinking of any
2 particular merchants when you mentioned that some apparently
3 had reduced their margin.

4 THE CHAIRMAN: I have been under the
5 impression that that was the case in the supermarkets,
6 they do reduce the margin substantially. I don't know
7 if they are increasing their reductions to a great extent
8 now, but they certainly did.

9 MR. TURNBULL: In days gone by.

10 THE CHAIRMAN: And the fact they were
11 selling more they could do it?

12 MR. TURNBULL: Yes.

13 THE CHAIRMAN: In relation to cost. Sales
14 went up, therefore they were able to reduce their margin
15 and still have a more profitable sale and still further
16 increase their sales. That was the theory I understood
17 they worked on. It seems to me it turns up in certain
18 periods of their history.

19 MR. TURNBULL: Of course, as we have attempted
20 to point out to the Commission that in rendering of
21 pharmaceutical services there is no such thing as a self
22 service or slot machine operation, but much of it is
23 involved in the professional services that is attached
24 to each and every prescription and therefore possibly some
25 of the cost saving that could be realized by the so-called
26 supermarkets and other such operations are not particularly
27 related to the -- any such similar savings that might be
28 made in rendering of professional services, individual
29 professional services.

30 THE CHAIRMAN: That type of saving would



1 be available if increasing volume reduced your cost per
2 dollar on the sale? Is it unreasonable to think some
3 pharmacists might consider that a circumstance that might
4 lead them to reduce their prices to some extent?

5 MR. TURNBULL: Of course, I presume in the
6 light of some of the information which the newspapers have
7 very gladly made available to us in their so-called surveys
8 that some pharmacists have undertaken such procedure and
9 that is why, possibly, you find the variation in pricing.
10 It would be one of the factors in pricing variation across
11 the country.

12 THE CHAIRMAN: I was wondering whether your
13 Association itself thinks that is something which might
14 be reasonably expected?

15 MR. TURNBULL: I think we have placed our-
16 selves here that the cost and price was charged -- the
17 man with the large prescription practice is possibly correct
18 and if the man who has a smaller practice sees fit to
19 enter into competitive field by maintaining his prices
20 at a comparable level so he can compete, possibly the
21 resulting income is not so great from a small proportion
22 of services and he is subsidizing his prescription
23 department from the front store operation business. Mr.
24 Ross, do you have something you want to say?

25 MR. ROSS: Mr. Chairman, I would like to go
26 back to the original question a few moments ago, that is
27 the way in which the Association looks on the rendering
28 of pharmaceutical services. I don't know whether it is
29 clear in your mind. I think it would be safe to say the
30 Canadian Pharmaceutical Association does, indeed, believe



1 that the price of these pharmaceutical services is a
2 package price for the service performed and therefore we
3 make no distinction between the commodity and the final
4 prescription and the service performed in dispensing the
5 prescription. The one price is the price of the service,
6 see to speak.

7 THE CHAIRMAN: You refer to the whole thing
8 as a service?

9 MR. ROSS: That is correct.

10 THE CHAIRMAN: No part is sale of goods?

11 MR. ROSS: That is correct.

12 MR. TURNBULL: Right.

13 MR. WHITELEY: Mr. Turnbull, we were dis-
14 cussing on page 96 the commodities supplied by the pharma-
15 cist is responsible for a larger proportion of the final
16 price of the service. The point I was raising arises out
17 of the statement made on page 101. At about the middle
18 of the first paragraph it was pointed out the maximum
19 difference in cost prices expressed as a percentage of the
20 lowest price was 83.3%. The survey showed as much as
21 50% variance in prices paid for different purchases from
22 a manufacturer and up to 39.2% variance in the prices
23 from a wholesaler. If with such wide variation in the
24 commodity and as the commodity forms such a large propor-
25 tion the question I was raising, why this wouldn't lead
26 more readily to differences in the price than as you point out
27 having the opposite effect.

28 MR. TURNBULL: We are not saying that
29 prices don't differ, sir. That sentence doesn't say the
30 prices of the overall services can't differ from store to



1 store. We are pointing out that this fact, that a tangible
2 item is a substantial portion of the complete service has
3 the effect of making it more difficult for a pharmacist
4 to lower a price that is, shall we say, overall service
5 even with a higher volume than it would be for members of
6 other professions.

7 MR. WHITELEY: That is the point I have
8 difficulty grasping. If the commodity is such a large
9 proportion and if there is such a large variation in its
10 cost then it seems to me the professional man in that
11 situation has greater opportunity than in the situation
12 where the cost is standard and it is not
13 affected by having to meet purchases of commodities?

14 MR. TURNBULL: Let me use an example, if
15 I may. The doctor, let us say, charging \$5.00 for an
16 office visit encompassing one half hour, during the course
17 of that one half hour he may use no more -- not consider-
18 ing his lights and rent and whatnot as overhead, and that
19 type of thing, because we can consider those are fairly
20 constant things -- he may use no more than a bit of ink
21 and one piece of paper on which to write out a prescription,
22 and even that piece of paper might have been provided to
23 him.

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W/dpw

1 At the same time, the pharmacist in rende-
2 ring a five-dollar pharmaceutical service, which we under-
3 stand could take on the average of 8 minutes, has used,
4 in addition to several pieces of paper, shall we say,
5 \$2.50-worth of tangible goods in the prescription. There-
6 fore, he is only able to lower his price by 50% if he is
7 going to pay for the item that he is giving as part of
8 his professional service; whereas a physician can be
9 considered as being able to lower his price, in that
10 there is no tangible product involved of 5¢.

11 That is all we are trying to say, sir.

12 MR. WHITELEY: Yes, but of course that is
13 passing beyond the point that this \$2.50 item may vary
14 from \$1.50 to \$3.50.

15 MR. TURNBULL: No, that bears no relation-
16 ship to our discussion at the moment. Our discussion at
17 the moment is a hypothetical five-dollar fee for an over-
18 all service, and whether that \$2.50 item in relation to
19 page 151 was bought from a source where the price happened
20 to be 83.3% lower than the highest price available, it
21 was still \$2.50.

22 MR. WHITELEY: I see the point you are trying
23 to make, is that it is more difficult for him to vary that
24 part of his price which consists of his special fee.

25 MR. TURNBULL: That is correct.

26 MR. WHITELEY: I see. I thought you were
27 following Mr. Ross' interpretation that the price of the
28 service is the entire price.

29 MR. TURNBULL: It IS the entire price. We
30 consider, as Mr. Ross pointed out, a pharmaceutical service



1 as a package service, definitely, but that package involves
2 a very tangible product that has a very tangible dollars
3 and cents cost on it, as opposed to using the physician's
4 service that we used a moment ago. The same fee has a
5 very small fee in tangible product cost attached to it.
6 Therefore the swings in the fee that has no tangible pro-
7 duct as part of it can be considerable, whereas the fee
8 that has, shall we say, 50% of it involved in a cost, a
9 basic cost, can't swing as far. We are not taking into
10 account the overhead costs and what-not that are common
11 to any pricing, that you must keep the lights on and the
12 heat, and that type of thing. We are not making any
13 reference to the variable prices that might be attached
14 to this package service.

15 As you point out, possibly some could claim
16 80%, one way or the other, but that is a comparison of
17 one pharmacist's service to another pharmacist's service.
18 We are here saying, "Than it would be for members of
19 other professions", that is all.

20 MR. WHITELEY: Let us take the situation
21 that these swings in costs are related to volume business,
22 as I assume they are. In other words, that the lowest
23 price would relate to the largest volume purchased, which
24 would be reflected in the amount of prescription business
25 done.

26 MR. TURNBULL: Yes.

27 MR. WHITELEY: If that is the case, then
28 wouldn't that provide scope if the pharmacist increased
29 his volume very substantially?

30 MR. TURNBULL: It would provide scope, yes,



1 not the scope that is available to any profession, no, but
2 it would provide the scope in a scope related, one pharma-
3 cist to another pharmacist. But that was not entering
4 into our discussion at this particular moment.

5 We are relating the pharmacist's service to
6 the service rendered by members of other professions, that
7 is all, the opportunity for variable variations in profes-
8 sional package fees.

9 THE CHAIRMAN: It might be a little puzzling
10 to take doctor's fee in which there is practically nothing
11 of tangible content ---

12 MR. TURNBULL: Right sir.

13 THE CHAIRMAN: His fee is entirely for his
14 professional service, with no product entering into it.

15 MR. TURNBULL: Yes sir.

16 THE CHAIRMAN: In setting the package price
17 for pharmacist's services, there is taken into account the
18 fact that there is a substantial product element.

19 MR. TURNBULL: Yes.

20 THE CHAIRMAN: - that must be taken care of.

21 MR. TURNBULL: Yes.

22 THE CHAIRMAN: If that substantial product
23 element varies from \$1.50 to \$3.50.

24 MR. TURNBULL: Yes.

25 THE CHAIRMAN: - may not the total package
26 price be affected for that reason, because your total
27 package price has been set, having in mind the cost of
28 your product, and if the cost of that product goes down
29 substantially, wouldn't the cost of the total package go
30 down?



1 MR. TURNBULL: Yes sir, I presume it does.

2 THE CHAIRMAN: It does give room for a
3 variation in the price of the package.

4 MR. TURNBULL: Oh, I am extremely sorry,
5 because our sentence reads, "This very fact makes it more
6 difficult for a pharmacist to lower the price of his
7 service with a higher volume than it would be for members
8 of other professions, since the pharmacist assumes a
9 larger variable cost per service than do the other profes-
10 sional groups".

11 We are not discussing the variables of one
12 pharmacist to another pharmacist here. We are merely
13 discussing that it becomes difficult, it is difficult as
14 one pharmacist increases his volume, to get involved in
15 any variable price to the extent that such variations
16 could take place in other professions.

17 MR. WHITELEY: I see what you mean, yes.

18 THE CHAIRMAN: Because you have got this
19 more or less fixed cost of the product element?

20 MR. TURNBULL: Yes.

21 THE CHAIRMAN: You have not as much to work
22 on that is entirely your own professional revenue?

23 MR. TURNBULL: No.

24 Price Coding

25 The Director's Statement, paragraph 464,
26 refers to, "... pharmacists are urged to use a code to
27 mark the price which they have charged on a prescription
28 so that if it is refilled by another pharmacist, the same
29 price can be charged".

30 There are many reasons for marking



1 prescription copies with a price code. First, it should
2 be clear that it is proper for a patient to request, and
3 to receive a copy of his original prescription which is
4 maintained on the file records of the pharmacist and, at
5 the same time, it is the pharmacist's responsibility to
6 prepare such copy to ensure that reference to it will
7 leave no doubt as to the full extent of the pharmaceutical
8 service originally rendered.

9 1. The confidence which a patient has in
10 his medication is often the difference
11 between good therapy and indifferent therapy,
12 and nothing destroys such confidence faster
13 than a variety of pricing, particularly
14 when refills are obtained at locations other
15 than the original pharmacy.

16 MR. WHITELEY: If the price goes up, does it
17 destroy the confidence, or if the price goes down, does it
18 destroy the confidence?

19 MR. TURNBULL: Both.

20 MR. WHITELEY: Merely that it is different.

21 MR. CARIGNAN: Why would the variety of
22 pricing destroy the confidence of a patient? It may well
23 destroy the confidence in the pharmacist who charged the
24 higher price, but why in the drug itself?

25 MR. TURNBULL: I think if I might use an
26 example: supposing before you gentlemen came to Toronto,
27 you had received a prescription in Ottawa and let us say
28 it cost you \$6. But because you were coming to Toronto
29 for an extended period, the range of which you did not
30 know, you asked for a prescription copy and you got just a



1 bare copy indicating that it was a copy. Then you had it
2 refilled in Toronto, shall we say, at \$4.25 - or let us
3 use the other, \$7.50.

4 Knowing what you do know about drugs and
5 prescription pricing now, immediately the question would
6 appear in your mind, "Who was right?"

7 If the man in Ottawa was right, the man in
8 Toronto must be wrong, and therefore you think, "What am
9 I getting? Am I getting the same drug as was given me in
10 Ottawa? Is this the drug that the doctor intended me to
11 have? Is this fellow just trying to pull a fast one on
12 me? Is he giving me something that might be cheap junk
13 in the lower case and charging me a comparable price?"

14 All those little doubts come into your mind.
15 How are you going to regard your ingestion of that parti-
16 cular prescription?

2 That is what we are driving at here. We
17 develop this a little bit further as we go.

19 Naturally in a small amount of 10 or 15 or
20 25¢ here and there, that does not enter into it, but these
21 things do enter into pricing confidence. If you were in
22 my office where quite often people pick up the 'phone just
23 on this basis and, particularly during the tourist season,
24 people will 'phone that they have received a prescription
25 from a Toronto drugstore and they don't know whether it is
26 quite what they should have been getting or not. We in
27 Saskatchewan, of course, do not trust anybody in Toronto
28 or vice versa.

29 THE CHAIRMAN: I can see the point, but
30 perhaps in talking to members of this Commission, you are



1 talking to the wrong people. We normally assume there
2 might be many reasons why prices charged to different
3 people will be different.

4 MR. TURNBULL: The Director's Statement
5 includes this statement, sir, and we feel we should
6 comment on it to bring these matters to your attention.

7 It is not something that we feel needs to
8 be hidden, and also of course we will develop and point
9 out that the Director's use of the term "Pharmacists are
10 urged to use a code", is certainly an unknown thing to us
11 because we cannot find anything in our literature anywhere
12 where the code even got started in Canada. Maybe the
13 Director has found that and historically it would be of
14 great value to us.

15 2. Price may often be a second check on
16 strength and dosage formulation in addition
17 to the brand or maker's name of the prepara-
18 tion supplied.

19 If you wish an extension of this, we discus-
20 sed legibility of writing, and what have you, yesterday,
21 and all these things do help the second man who may be
22 called upon to refill a prescription.

23 3. The very fact that a price might be
24 marked on a prescription copy is, in itself,
25 evidence of the fact that pharmacists do not
26 charge the same price for prescriptions.

27 4. The original prescription may have been
28 filled in an area in which overhead is low
29 and prices lower than average. Such pricing,
30 as divulged by the code, or otherwise, is



1 usually honoured in another area.

2 5. Some pharmacists have stopped using any
3 code and now mark all prescription copies
4 with the price charged, in normal figures.

5 6. During the past two decades, in parti-
6 cular, prices have been known to fluctuate
7 greatly and the cost of a refill may be
8 substantially less or greater, depending
9 upon the elapsed time.

10 Then, I might add, such information is of
11 value to the first man. I know that it happens on many
12 occasions. The patient brings his original prescription
13 back to the pharmacist who first dispensed it and it saves
14 a lot of time in checking on the refill and any further
15 explanations.

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MR. TURNBULL:

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7. The source of the Director's suggestion
3 that "pharmacists are urged to use a code..."
4 is not known to this Association. It is
5 known that such practices are followed,
6 but we are unable to find any reference
7 to such in literature of the past decade
8 or so.

9

Rebates and Ethics

10

At the Commission's Halifax hearings, a
11 'witness' inferred, by quoting from an
12 American publication, that physicians
13 expected financial rebate from drugstores
14 and medical supplies houses. To the
15 knowledge of the Canadian Pharmaceutical
16 Association, absolutely no such rebate
17 practices or "kick-backs" take place.
18 Further, it is emphasized that such practices
19 are deemed to be highly unethical and not
20 in the best interests of the professions
21 concerned nor of the patient, and any
22 reports of such would immediately be made
23 known to the professional associations of
24 the persons involved.

25

THE ASSOCIATION AND ASSOCIATION ACTIVITIES

26

Dual Personality?

27

In the Director's Statement, references
28 are made to a so-called dual personality of Pharmacy's
29 associations and their officers. In earlier sections of
30 this Association's brief, an attempt has been made to



1 orientate the various pharmacy organizations in Canada,
2 and from those sections it will be realized that in most
3 provinces there are usually found two active pharmacists'
4 province-wide organizations, one being the statutory
5 association, and the other a voluntary organization of
6 retail pharmacists. In the main, councillors of the
7 statutory organization are both pharmacy practitioners and
8 business men, and, hence, may exhibit a so-called dual
9 personality in keeping with their personal, day-to-day
10 practices, but any dual expression of thought as councillors
11 is more superficial than may appear to those outside the
12 profession.

13 Any accusation of dual personality appears
14 to relate to councillors' discussion of price matters as
15 well as matters strictly pertaining to the profession,
16 its practice and its members. Due to the commercial cir-
17 cumstances under which pharmacy in Canada is practised,
18 such matters naturally arise in that (a) problems
19 encountered in pricing usually enter into some phase of
20 academic training; (b) they are definitely a part of
21 interneship or apprenticeship training; (c) a pharmacy
22 organization must respond, for the betterment of public
23 relations, to individual demands which place it in the
24 position of an intermediary between the complainant and the
25 individual pharmacist in matters concerning practices which
26 may include alleged over-pricing and price variations,
27 and I mentioned the telephone calls a few moments ago.

28 In practising his profession, the pharmacist
29 is also engaged in a business. Thus, the pharmacist's
30 association may well undertake the rendering of services



1 and the study of problems which, in the eyes of some, may
2 be related to activities normally associated with trade
3 organizations. It would be extremely impractical to do
4 otherwise.

5 Moral Pressure?

6 From time to time, the Director's Statement
7 uses material which it considers to be in the nature of
8 informed comment or quotes from newspaper columns or from
9 letters which it has in its possession, but which do not
10 necessarily represent any degree of official thought on
11 any particular subject. Such was the case in paragraph
12 156 which follows reference, in paragraph 154, to "strong
13 moral pressure exerted against price cutting", and in
14 which are quoted comments by private pharmacists relative
15 to an article by a columnist of the Toronto Star on June 11,
16 1959. We regret the selection of this particular letter
17 for quotation in the Statement without similar reference
18 to other writings such as that published in The Toronto
19 Star June 15, 1959, as written by an officer of the
20 Canadian Pharmaceutical Association. Pharmacists' organiza-
21 tions have voiced opinions which are not unlike those voiced
22 by all retailer organizations in Canada --- namely, that
23 they oppose deceptive merchandising tactics, including
24 predatory price-cutting --- but all pressures in this
25 regard have been directed to governments, and never to
26 individual retailers or groups thereof.

27 Association Publications

28 It has been mentioned earlier that the
29 Association has a publishing department which, in addition
30 to the Canadian Pharmaceutical Journal, produces textbooks,



1 reference books, pamphlets and other material of value
2 to the profession. Each of these meets specific needs in
3 the practice of pharmacy in Canada, and include:

4 The Canadian Formulary (with or without

5 French addendum)

6 New Products Index (now replaced)

7 The Canadian Drug Store, A Market Analysis

8 Textbook of Pharmaceutical Arithmetic

9 Test and Improve Your Scientific Word Power

10 Price Book of Drug Store Merchandise

11 Compendium of Pharmaceutical Specialties

12 Canadian Pharmaceutical Journal

13 The Canadian Pharmaceutical Journal,
14 founded in 1868 and the oldest non-consumer journal still
15 published in Canada, is owned and published by the
16 Association. It carries the advertising of suppliers to
17 retail pharmacies and presents to its readers, columns
18 of new products information, therapeutic trends, pharmacy
19 administration, a scientific section, news of organizations,
20 as well as more general articles of specific interest to
21 practising pharmacists, to assist them in their professional
22 and business activities.

23 Mr. Chairman, I would like to leave a price
24 book as an exhibit, if I may. That is a price book of
25 drug store merchandise, volume 22, dated June 1961.

26 THE CHAIRMAN: This book as described will
27 be exhibit T-17.

29 ---EXHIBIT T-17:

30 Price book of drug store
merchandise, volume 22,
dated June 1961.

1 MR. TURNBULL:2 The Price Book

3 Twenty-two editions of the Price Book of
4 Drug Store Merchandise have been published since 1951.
5 As stated on its cover, "the prices listed in this book
6 are the retail prices published by the manufacturers as
7 of(such and such a date). No retailer is under any
8 obligation to adopt all or any of the prices listed". It
9 is a compilation in one place of the price lists of over
10 125 companies within one cover, and up-dated copies are
11 offered for sale twice yearly on the publication dates
12 of June 1 and December 1. These publication dates have
13 been found to be preferred because the purchasers wish to
14 have an up-to-date reference book at times when new staff
15 and increased merchandise are most likely. The June issue
16 comes at a time when newly graduated pharmacists are
17 taking their place in retail pharmacies and when holiday
18 staff are most prevalent. The December issue meets the
19 many reference requirements of extra staff during the
20 pre-Christmas season and, more important, assists the
21 pharmacy with its year-end inventory calculations.

22 The Price Book gives the retail pharmacy
23 ready access to reference information for products that
24 are regularly stocked, as well as products which may be
25 requested, or for those produced by manufacturers with
26 whom the pharmacist may not be familiar. This reference
27 book enjoys a wide demand and, although it does contain
28 many dozens of items which are not prescription drug items,
29 it might well be of use to physicians who wish to have
30 ready access to general price information. A recapitulation



1 of the distribution of the last three volumes of the Price
2 Book is presented herewith: We might just look at
3 volume 22 related to the exhibit. Total sales of 1,586,
4 at a price by the way of \$6.00 per copy; retail pharmacists
5 including a few physicians, 1,493; hospitals, 24; govern-
6 ment, 10; manufacturers, 57 copies, and advertising
7 agencies, 2. I would ask that that table be taken as
8 read, Mr. Chairman.

9 THE CHAIRMAN: Yes.

10 MR. TURNBULL:

11	Vol. No. (& Date)	Total Sales	Retail Pharma- cists*	Hospitals	Gov't.	Mfrs.	Advtg. Agencies
12	#20 (June, 1960)	1502	1397	21	-	83	1
13	#21 (Dec., 1960)	1576	1522	13	6	35	-
14	#22 (June, 1961)	1586	1493	24	10	57	2

19 *includes a few physicians

20 Cost prices are quoted in the industry as
21 discounts from the manufacturer's list price. List prices,
22 as printed in manufacturers' catalogues, to our knowledge
23 pertain to all areas of Canada, while discount structures
24 vary from time to time with special offerings and from one
25 area to another, and between sources of supply. Different
26 levels of sources of supply often have a great effect upon
27 the cost price to a retail pharmacist but such variances
28 may be compensated by other expense factors, such as
29 overhead and wages, in keeping with his level of business



1 volume.

2 Recently the C.Ph.A. asked several retail
3 pharmacists in all provinces except Newfoundland what they
4 would pay for specific package sizes of eight specific
5 prescription drug items and sundry items at different
6 times and through different sources. List prices remained
7 consistent over the period of study. The results of this
8 study are set forth in the table on page 103 which shows
9 percentage variances (total; purchases through wholesalers;
10 direct purchases from manufacturer) in prices at which
11 such product was available under circumstances pertaining
12 to each respondent to the survey. Maximum difference in
13 cost prices, expressed as a percentage of the lowest price
14 -- not the average price -- was 83.3%. The survey showed
15 as much as 50% variance in prices paid for different
16 purchases from a manufacturer, and up to 39.2% variance
17 in prices from a wholesaler. Therefore, the publication
18 of price information which included cost prices, only,
19 would appear totally impractical. List prices, on the
20 other hand, represent price levels of a relative consistent
21 nature upon which the pharmacist, from his knowledge of
22 discounts available to him, may compute his costs through
23 different sources at the various trading levels.

24 Compendium of Pharmaceutical Specialties

25 The Compendium of Pharmaceutical Specialties
26 (Canada) 1960 edited by F.N. Hughes, Dean of the Faculty
27 of Pharmacy, University of Toronto, and published by the
28 Canadian Pharmaceutical Association, is a reference text-
29 book available to the practising pharmacist and physician
30 which gives, in abbreviated form unbiased information on



1 pharmaceutical specialties available in Canada. In 500
2 pages, the original volume of the Compendium presents
3 7,776 pharmaceutical specialties, each monographed as to
4 manufacturer, description, indication, administration
5 and how supplied, plus coding pertaining to certain legal
6 restrictions. It includes an extensive Therapeutic Index
7 and a listing of manufacturers' addresses. It is kept
8 up to date with semi-annual supplements, and each month
9 the very latest information is published in the Canadian
10 Pharmaceutical Journal.

11 Prior to its publication in November, 1960,
12 sale of the Compendium was advertised to pharmacists and
13 physicians so that knowledge of the availability of such a
14 comprehensive compilation of information would be known.
15 3,047 practising pharmacists, (2,784 retail, 199 hospital,
16 64 armed forces) and 55 physicians have purchased The
17 Compendium, to date.

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1 MR. TURNBULL: There are other reference publications or
2 listings which provide information about pharmaceutical
3 specialties in Canada, although not of the extensive
4 nature of The Compendium. The Vademecum International
5 contains descriptive monographs and brief listings of
6 some 3,000 products. Drug Index comprises a comprehen-
7 sive list by product and name of manufacturer.

8 Price information is not included in The
9 Compendium of Pharmaceutical Specialties as the editor
10 felt that it would be physically impossible for him to
11 keep track of price changes. This information, as men-
12 tioned above, is available in another Association publica-
13 tion, the Price Book, which lists pharmaceuticals, patent
14 medicines and sundry items alphabetically with their list
15 prices.

16 THE CHAIRMAN: I think Mr. Turnbull we should
17 have a break now.

18 MR. TURNBULL: May I just before the break,
19 ask that page 103, the table appearing on page 103 be taken
20 as read?

21 THE CHAIRMAN: Yes.

22 MR. TURNBULL: Thank you sir.

23
24 --- Short Recess

25
26 MR. TURNBULL: To our original brief we have
27 attached an addendum, being page 103a.

28
29
30



ANGUS. STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Turnbull

2580

"VARIANCE IN PRICES PAID BY RETAIL PHARMACISTS FOR A SPECIFIC SIZED

PACKAGE OF EIGHT SPECIFIC COMMODITIES — DUE TO QUANTITY

PURCHASED AND SOURCE OF SUPPLY

(Maximum Difference in Prices paid expressed as a percentage of lowest Price)

	OTC Pharmaceuticals		Rx Drugs		Proprietary		Sun-dries	
	A	B	C	D	E	F	G	H
	Direct							
	Variance %	25.0	25.0	--	14.0	--	20.0	5.2 11.2
	Wholesale							
B. C.	Variance %	1.9	11.1	1.9	2.1	1.9	11.4	11.1 2.9
	Total							
	Variance %	35.3	45.0	16.7	23.5	27.0	40.0	15.8 25.3
	Direct							
	Variance %	50.0	25.0	--	--	8.3	21.5	11.1 --
	Wholesale							
Alta.	Variance %	16.0	1.0	1.0	1.0	9.9	3.2	6.3 --
	Total							
	Variance %	79.9	50.0	18.9	11.1	13.7	50.1	18.5 8.0
	Direct							
	Variance %	19.9	17.6	--	--	--	7.7	-- --
	Wholesale							
Sask.	Variance %	2.9	13.4	--	--	18.6	12.1	5.3 4.0
	Total							
	Variance %	30.7	36.1	8.0	9.5	18.6	24.5	5.3 9.0
	Direct							
	Variance %	20.0	47.1	--	5.3	11.2	9.2	2.1 5.8
	Wholesale							
Man.	Variance %	28.0	16.3	5.4	2.9	11.2	11.1	21.2 5.0
	Total							
	Variance %	44.0	76.5	13.3	17.0	21.4	25.1	21.2 11.1
	Direct							
	Variance %	50.0	47.1	--	5.4	--	20.0	-- --
	Wholesale							
Ont.	Variance %	11.2	13.3	15.0	11.1	4.8	20.2	39.2 22.3
	Total							
	Variance %	66.6	83.8	27.5	30.1	36.3	49.8	39.2 25.0
	Direct							
	Variance %	41.2	38.9	--	--	--	9.2	-- --
	Wholesale							
Que.	Variance %	11.1	5.1	0.0	--	11.2	5.0	11.1 5.0
	Total							
	Variance %	56.9	62.0	20.0	11.1	20.1	27.4	11.1 13.6
	Direct							
	Variance %	20.0	37.9	--	11.1	17.6	3.3	9.3 --
	Wholesale							
N. B.	Variance %	11.2	8.1	11.1	11.1	23.3	9.1	23.7 20.0
	Total							
	Variance %	33.3	65.5	10.9	23.5	45.0	26.3	23.7 20.0
	Direct							
	Variance %	20.0	47.1	--	--	--	0.3	-- --
	Wholesale							
N. S.	Variance %	--	2.9	2.9	3.5	12.7	2.9	25.0 2.9
	Total							
	Variance %	33.3	76.5	20.0	15.0	12.7	30.0	25.0 16.9
	Direct							
	Variance %	20.0	37.9	2.0	--	--	0.3	17.3 14.3
	Wholesale							
P.E.I.	Variance %	--	2.9	--	--	12.6	--	11.1 11.1
	Total							
	Variance %	33.3	65.5	13.9	11.1	12.6	26.3	19.3 14.3
	Direct							
	Variance %	50.0	47.1	2.0	14.4	47.4	20.0	23.5 26.5
	Wholesale							
Canada	Variance %	20.0	22.5	19.2	15.0	35.1	20.2	39.2 25.0
	Total							
	Variance %	80.0	83.3	27.5	34.6	57.2	50.1	39.2 31.7



ADDENDUM

In appearing before this Commission during its Montreal hearings, a Mr. K. Antoft who is associated with a company which markets certain pharmaceutical preparations, presented rather regrettable comments, regrettable to us, related, as he put it, to "the role of the retail druggist in Canada" and to "retail pricing".

Danish Pharmacy vs Canadian Pharmacy

Mr. Antoft's references to Danish Pharmacy are more or less correct, although to some who have grown up in a completely free enterprise system, the colours in his picture may not be so glowing. Denmark, with a land area of approximately two-thirds that of Nova Scotia, or a little greater than that of Vancouver Island, has a population of four and one-half million people of whom approximately one million reside in the City of Copenhagen.

From personal observation gained during an international meeting in Copenhagen in September, 1960, the C.Ph.A. Secretary-Manager noted that Danish pharmacies do sell certain over-the-counter items --- mostly common patent medicines and cosmetics --- but, according to his Danish colleagues, these are only available because tourists expect to find them there. It was indicated to the C.Ph.A. Secretary that there are 650 pharmacists to serve the Danish population (or one pharmacist per 6900 persons). It may possibly be that that fine country, with its relatively dense population within a political system of social democracy, is well served by the pharmacy population ratio quoted.

THE CHAIRMAN: Have you any information as to



1 where the general mass over-the-counter products might be
2 sold in Denmark?

3 MR. TURNBULL: In general, from my experience
4 sir in Copenhagen - limited to the City of Copenhagen,
5 the business establishments are somewhat like what we
6 experienced maybe two or three decades ago. That is,
7 according to specialty shops. In fact, there is a high
8 degree of specialization in merchandising in Copenhagen.

9 I believe there is one or possibly two
10 department stores only and the patent medicines and such
11 cosmetics are evenly divided in their sales outlet. You
12 will find the same in practically all lines of commerce.

13 There is no such thing as a man's shop.

14 A man will buy his hat in one store and his
15 shirts and ties in another. His suit in another. His
16 shoes in another ~~and~~ socks in another, ~~and~~ that type of
17 thing, and the same specialization is found in patent
18 medicines and cosmetics.

19 There is certainly not what we might commonly
20 call Mama and Papa stores. Very fine establishments.
21 Very fine business establishments.

22 I don't know if there is any type of Govern-
23 ment control at any level of Government over the establi-
24 shing of these business outlets as there is in pharmacy,
25 however.

26 Pharmacies are rigidly controlled in number
27 and location. New ownership comes from being permitted to
28 purchase upon the retirement (enforced at age 70 years) of
29 a pharmacy owner, or upon the announcement of a new phar-
30 macy location being agreed to. The applicant for this



1 available pharmacy location will have had at least 13
2 years pre-college education, 2 years apprenticeship and
3 years Pharmacy plus at least 14 years experience as an
4 assistant pharmacist before being allowed to apply to take
5 over a pharmacy, and even then, must be able to show an
6 "A" academic average as well as the financial ability to
7 purchase at the price agreed upon by the government and
8 the previous owner. In other words, a potential new owner
9 will be approaching 40 years of age, but cannot be more
10 than 50 years of age, and faces the fact that he must
11 retire at 70 years. The pharmacist-owner is free to build
12 up his clientele. At the same time, he is guaranteed a
13 certain level of annual income by the government which is
14 prepared to subsidize the pharmacy practice if such should
15 be found necessary to ensure that the community continues
16 to have pharmaceutical services available. Prescription
17 services are insured, and an insuring agency and the govern-
18 ment (actually, in this case, the Danish Pharmaceutical
19 Association) and the patient sharing the bill.

20 In a system which he found in Sweden and
21 which appears common in many Scandinavian countries, many
22 Danish pharmacies are, in fact, small pharmaceutical 'fac-
23 tories' which often act as compounding centres for a group
24 of pharmacies within an area. Area pharmacies buy such
25 preparations, (tablets, injections, ointments, etc.) at
26 certain set cost prices and, in turn, dispense them at
27 certain set prices.

28 Canadian Pharmaceutical Journal

29 Contrary to Mr. Antoft's accusation, the
30 Canadian Pharmaceutical Association and its official



1 publication, the Canadian Pharmaceutical Journal, has in
2 the past, does at the present time, and will continue to
3 do so in the future, placed emphasis upon the enhancement
4 of the professional activities of practising pharmacists
5 in Canada. At the same time, the Association recognizes
6 that community pharmacies are engaged in commercial enter-
7 prise and must meet the day-to-day challenges of business
8 activities as apart from their role in providing pharma-
9 ceutical services. It is sheer misrepresentation to state
10 that the Canadian Pharmaceutical Journal shows any preoccu-
11 pation with purely commercial activities. The Director
12 has, in his possession, many, if not all, of the issues of
13 The Journal of the past several years and the Commission
14 has probably had an opportunity of judging these matters
15 for itself.

16 In June, 1961, with a change of editorship
17 in the offing, the Association conducted an
18 intra-office study of The Journal --- its
19 production, format, editorial make-up and
20 advertising content - and I would like to
21 present that as an exhibit sir.

22
23 --- EXHIBIT NO. T-18: Intra-office study of Canadian
24 Pharmaceutical Journal.

25
26 MR. TURNBULL: The cover depicts our Presi-
27 dent at that time being interviewed by a C.B.C. television
28 man. At that time the interest in this problem was some-
29 what more rampant in public circles than it appears to be
30 at the present time.



The eleven issues of June, 1960 to May, 1961 (September, 1960 presented here as a most worthy Exhibit, was omitted due to its exceptionally heavy editorial content) contained a total of 322.6 editorial pages, 20% of which was in the French language, classed as follows:

Do you wish me to read the chart sir?

THE CHAIRMAN: I don't think it is necessary.

MR. TURNBULL: I would ask that it be taken as read.

THE CHAIRMAN: Have you any comments on the relative proportions?

MR. TURNBULL: Yes, if I may.

Category	Description of Category	Total Pages	% of Editorial	% of Total Magazine Pages
Associations	C.Ph.A.; Prov. Assoc.; C.Ph.A. affiliates; C.P.M.A.; P.A.C.; Internat.	50.1	15.5	8.7
General	P-M; History, Industrial; Letters; Poison Control; Publicity	42.4	13.1	7.4
News	News of Pharmacy, Pharmacists and Manufacturers	35.2	11.0	6.1
Practical Pharmacy	Items concerning Pharmacy or financial operations or products	64.0	19.8	11.1
Professional Pharmacy	Items related to the pharmacist and knowledge of drugs and health	73.5	22.8	12.8



1	2	Description of Category	Total Pages	% of Editorial	% of Total Magazine Pages
3	Category			Content	
4	Scientific	Items requiring advanced knowledge-largely the Scientific Section	35.4	11.0	6.2
5	Magazine Layout	Cover and title page only	22.0	6.8	3.8
6	TOTALS		322.6	100.0%	56.1%

8
9 Total Magazine Pages for Eleven Issues (including covers) - 576
10
11 Total Editorial Content of Eleven Issues - 322.6 pages
12 The 64 pages (19.8%) categorized as
13 "Practical Pharmacy" contained new products
14 monographs, a regular administration column,
15 and ---- 2 pages re o-t-c sales making -
16 over-the-counter sales making -
17
18 4 pages re photography
19
20 2.5 pages re cosmetics
21
22 2 pages re special gift promotion
23
24 15 pages re modernization and renovation
25
26 5.5 pages re new sundry items and deals - that is the manufacturers'
27 pages
28
29 Without attempting to review the Scientific Section (35.4 pages), the topics and titles under "General" and "Professional Pharmacy" totalling 115.9 pages (35.9%) include:
30



- 1 "History of Vitamin C"
2 "Channels of Distribution in the
3 Vitamin Market"
4 Vitamin Deficiency Chart
5 "Taste, Odour and the Pharmacist"
6 "Diabetes Mellitus Orally Effective
7 Agents"
8 "What is Public Relations?"
9 A variety of Book Reviews
10 "Aspects Pharmacologique et Thera-
11 peutique des Derives de la Phenothia-
12 zine"
13 "Drug Safety Insurance"
14 Therapeutic Trends
15 "A Medicinal Plant Garden"
16 "Is Staying Alive Too Costly?"
17 "A Composite Pharmacy of 1870"
18 "PR and Promotion"
19 Industrial Pharmacy
20 From Pharmacy's Past
21 "Oral Contraceptives"
22 "Pathology of the Urinary Tract"
23 "Jet-Milling Steroids"
24 "The Perfumes in Medicine"
25 "Silicones"
26 Test Your Word Power
27 "Vernous and Abdominous" - that is
28 also a word power article -
29 "Support National Health Week"
30 "Do Retail Pharmacists Deserve



- 1 Professional Status?"
2 "Anemia"
3 "More Than Potency"
4 "The Secret Signs of Alchemy"
5 "A Smear is Analysed"
6 Poison Control
7 "A Canadian-Soviet Medical Research
8 Project"
9 "Whither Pharmacy"
10 A Prescription Drug Survey
11 "Pharmaceutical Elegance"

12 Advertisements in The Journal are directed to
13 the practising pharmacist and, as opposed to those for the
14 same products which appear in, for example, the Journal of
15 the Canadian Medical Association, place more emphasis upon
16 business proposals than upon advantages to be gained by
17 the medical use of the preparation. This may not be 'con-
18 sidered' altogether correct, but it is certainly part of
19 the practical information the practising pharmacist must
20 have. Advertising respecting non-prescription items natu-
21 rally attempts to woo the business of the retail dealer
22 by placing emphasis upon special deal profits, including
23 the use of \$\$\$ signs which, to some, during the past year
24 or so, have become repugnant. This is not a situation
25 which has developed over the past few years. Similar
26 advertising, written in the language of the day, is found
27 in the Canadian Pharmaceutical Journal of the late 1800's.

28 Advertising revenue is, of course, important
29 to the Association's publication and this is
30 reviewed each year in setting our budget.



1 During the 1960 calendar year 25 pharmaceutical manufacturers (i.e., C.P.M.A. members)

2 used 110.5 advertising pages, with the

3 balance of the 270.5 page total being used

4 to advertise patents and

5 proprietaries, 50 pages

6 cosmetics, 13 pages

7 fixtures, 32.5 pages

8 photographic, 14 pages

9 others, 50.5 pages

10 A readership survey of the Canadian Pharmaceutical Journal, conducted by mail in late

11 1957, was responded to by readers from a

12 geographical, employment, and rural-urban

13 cross-section in the same percentage ratio

14 as our total subscription list. It told us:

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1 MR. TURNBULL:

2 Do you read The Journal regularly, occasionally or only
3 sometimes?

4 90% regularly

5 9% occasionally

6 1% only sometimes.

7 THE CHAIRMAN: Mr. Turnbull, referring back
8 to page 103d where you mentioned 25 pharmaceutical
9 manufacturers and have in brackets C.P.M.A. members, are
10 members of the C.P.M.A. the only advertisers?

11 MR. TURNBULL: No, that is why we added
12 that explanatory note in there. This, of course, is on
13 the 1960 calendar year and the figures that were obtained
14 for me were by a newly employed advertising manager, who,
15 at that point, was not too much aware of the different
16 categories of one manufacturer to another, so he had
17 given me these figures based on the known list that was
18 available to him of manufacturers who were members of the
19 C.P.M.A. as opposed to the wider list as brought out the
20 other day of 180 to 190 manufacturers who do, in fact,
21 produce pharmaceuticals in Canada.

22 THE CHAIRMAN: That wouldn't mean in the
23 Canadian Pharmaceutical Journal they don't have any
24 substantial advertising by manufacturers other than those
25?

26 MR. TURNBULL: Pharmaceutical manufacturers,
27 yes sir.

28 THE CHAIRMAN: That is only a partial list?

29 MR. TURNBULL: That is only a partial list
30 and the balance would be under the title of others. Some



1 of them, of course, in the proprietary field in that they
2 do not restrict their activities to the prescription drug
3 category only.

4 Do you read only the editorial material, only the
5 advertising, or both?

6 12% only the editorial material

7 2% only the advertising (These were all
8 company representatives.)

9 86% read both advertising and editorial.

10 THE CHAIRMAN: You did not get any reply
11 from people who said they didn't read anything?

12 MR. TURNBULL: I assume that would be the
13 one per cent that said "only sometimes".

14 THE CHAIRMAN: You have 86 and 14 which
15 would be 100%.

16 MR. TURNBULL: We were quite pleased with
17 our survey.

18 Do you read The Journal from "cover to cover", the majority,
19 or less than one-half?

20 19% from cover to cover

21 68% the majority

22 13% read less than half

23 Check the features which you read regularly.

24 80% read the editorial (that is editor's
25 comment)

26 62% read the Secretary's Desk

27 40% read From the Past (a historical column)

28 74% read the news items

29 70% read the Manufacturers Notes

30 87% read the New Products



1 65% read Pharmacy Administration
2 55% read Seminar (which deals with upcoming
3 drugs)
4 58% read Production and Marketing (one
5 step higher than the Seminar)
6 56% read the Scientific Section (devoted
7 to new publication of scientific
8 papers.)

9 Additional:

10 57% stated they kept copies and referred
11 back to them for at least one year.
12 An additional 14% filed certain sections
13 for later reference
14 Each copy is read by 1.69 persons. Since
15 every registered pharmacist receives
16 his or her own copy, the additional
17 readership is in the cosmetic and
18 unregistered clerk class. While not
19 pharmacists, these people do recommend
20 certain purchasing to owners.

21 Prescription Pricing

22 In Mr. Antoft's submission, it is suggested
23 that, "If he (the druggist) feels that he is entitled
24 to a professional fee, should list this fee as a separate
25 item to the prescription bill of the patient". We can
26 only remark here, as professional fee concepts have already
27 been amply discussed in this Association's presentation,
28 that such a move would be highly impractical --- in fact,
29 as impractical as suggesting that the manufacturer invoice
30 at his basic cost plus a separate figure representing the



1 "activities fee" pertaining to a drug item.

2 MR. FRAWLEY: What would you have in mind
3 as "activities fee"?

4 MR. TURNBULL: Activities, I believe, have
5 been discussed quite a bit during the hearing of this
6 Commission, Mr. Frawley.

7 MR. FRAWLEY: Seriously, I just wondered --
8 do you mean promotion, mail advertising, sampling and so
9 on?

10 MR. TURNBULL: Could be.

11 MR. FRAWLEY: I see.

12 MR. TURNBULL:

13 SUMMARY

14 This representation by the Canadian Pharma-
15 ceutical Association, Inc. to the Restrictive Trade
16 Practices Commission deals in some length with a discussion
17 of Pharmacy and the distribution of drugs in Canada with
18 particular reference to matters pertaining to drug costs
19 and prices at the various levels of distribution.

20 1. The Association, its constituent member
21 associations and its affiliated organizations
22 are keenly aware of their respective roles
23 and their obligations, statutory or other-
24 wise, to the profession of Pharmacy and to
25 the public of Canada. The Association has as
26 its objective the advancement of the science
27 and practice of Pharmacy as well as the
28 business interests of its members.

29 2. The Association greatly regret that
30 publicity of the past several months has



1 possibly resulted in the creation of a
2 degree of public misunderstanding which, if
3 allowed to continue, may seriously affect
4 the proper utilization of drug therapy and
5 the searching-out of even better drugs.

6 3. Historically, to the present day, Pharmacy
7 practice at the community level has been
8 associated with retail business enterprise.
9 Hence, the Association is mainly comprised
10 of pharmacists who, in addition to keen
11 professional interests, have accepted the
12 challenges of commerce. With the exception
13 of some 39 chain operations involving
14 approximately 431 locations, Canada's 4900
15 pharmacies are individually owned or con-
16 ducted as limited companies.

17 4. Drugs, but not necessarily complete
18 pharmaceutical service, are available to the
19 consuming public through sources other than
20 retail pharmacies, including hospitals,
21 dispensing physicians, government agencies
22 and military units, industrial medical rooms
23 and voluntary health organizations.

24 5. Legislation concerning drugs is designed
25 to police standards and to prevent fraudulent
26 activity, and to govern those who may dis-
27 tribute drug preparations in the best
28 interest of public health. It places
29 responsibility upon manufacturer, distributor
30 and practitioner and, quite rightly, does



1 not initiate administrative procedures which
2 would delegate this private responsibility
3 to government public service divisions.

4 6. Pharmaceutical research is a vital
5 undertaking ever worthy of encouragement.

6 Public funds utilized to promote primary
7 investigation, and the monies of voluntary
8 organizations placed in readiness to advance
9 advocated research channels and education
10 therein, exemplify the increasing need for
11 intensive application of private enterprise
12 capabilities in initial research, develop-
13 ment, formulation and production. While
14 it is to be acknowledged that the price of
15 drugs in Canada contributes extensively
16 to research and developmental expenditures
17 in many lands, Canadian Pharmacy is of the
18 opinion that more could be undertaken within
19 our own boundaries. We have already become
20 too reliant on foreign sources of supply.

21 7. Quality, quality control and drug
22 evaluation must continue to be a prime
23 responsibility of the individual producer
24 (manufacturer) and/or the distributor where
25 the two are not one and the same. There is
26 conclusive evidence against the acceptance
27 of mere quantitative control as a substitute
28 for quality evaluation. Also, there would
29 appear to be dangers inherent in evaluations
30 resulting from control organizations or



1 agencies --- indecisions, delays, differences
2 in opinions concerning new treatments and
3 procedures, and the burdensome procedures
4 of essentially disinterested personnel.

5 8. Promotion and advertising of drugs to
6 the profession is not inexpensive. It is
7 agreed that there is justification for claims
8 that there exists evidence of over-indulgence
9 in 'frills' in individual instances, but such
10 are not industry-wide. Saturation methods
11 of promotion need not be condoned and it is
12 believed that annoyances arising therefrom ---
13 direct mail methods and advertising copy ---
14 as well as potential dangers --- over-sampling
15 --- can be resolved to the mutual satisfac-
16 tion of all parties concerned. Efficient
17 promotion is the means by which efficient
18 distribution is achieved. It can do nothing
19 but enhance drug therapy, while expediting
20 the process which influences the lowering
21 of prices.

22 9. The price of no item or service, including
23 drugs and pharmaceutical services, at the
24 retail or private client level, can be
25 properly compared with costs at institution,
26 government or other non-profit levels. Drug
27 costs to the community retail pharmacy appear
28 to bear little, if any, relationship to the
29 cost of the same drugs purchased by hospitals
30 and government agencies. Many reasons are



1 advanced for this situation but, notwithstanding them, the Association is of the firm
2 belief that price difference should only
3 result from differences in quantity and/or
4 quality and/or dosage formulation.

5 The principle of equitable pricing
6 policies --- "equal price for equal quantity
7 and quality, with a reasonable and equitable
8 relationship between quantity price levels,
9 to all purchasing levels" --- is only proper
10 and fair to the ambulatory and hospitalized
11 patient, alike, and to those who privately
12 assume their own needs as opposed to having
13 them assumed by public resources. Adherence
14 to such a policy principle would substantially
15 decrease the cost of pharmaceutical service
16 rendered by the pharmacy practitioners in
17 our communities.

18
19 10. Patent legislation in Canada, quite
20 properly, protects the inventor while making
21 provision for overseeing the proper utilization
22 by, and distribution of the invention's
23 benefits in Canada. Pharmacy is of the
24 opinion that the intent of the Patent Act
25 suitably advances the best interests of the
26 Canadian public and provides a degree of
27 protection for the patent-holder against the
28 exploiter, but wishes its administration to
29 be such as to encourage development of a
30 distinctively Canadian pharmaceutical industry.



1 11. From the general use of official drugs
2 and extemporaneously prepared combinations
3 of them, brand-name pharmaceuticals evolved
4 and achieved popularity on the basis of
5 pharmaceutical accuracy and elegance.
6 Pharmacist and physician confidence was
7 built around the reputation of the maker's
8 name. As more brand-name specialties began
9 to be prescribed, knowledge of superior
10 quality control standards and safeguards
11 became vital to the pharmacist in the
12 assumption of his legal and moral obligations
13 as the supplier to the public. Modern
14 organic chemical drugs, specific in composi-
15 tion and in therapeutic activity, brought
16 forth a new vocabulary of complicated chemical
17 names and official as well as common or
18 generic nomenclature in addition to the
19 brand-name designations of their developers.
20 Combination-formulations for less specific
21 illness situations, produced with a lesser
22 degree of duplication and imitation, did
23 not lend themselves so readily to other than
24 a brand or company name designation. The
25 pharmacist and physician still must necessarily
26 turn to a reliance upon known qualifications
27 and reliability of the manufacturer.

28 The profession of Pharmacy does not
29 disagree with those who advocate that drugs
30 might best be prescribed by their chemical or



1 official or generic names. In the absence
2 of a physician's stated order by brand and/or
3 manufacturer's name, the pharmacist -- and
4 only the pharmacist --- is in a position which
5 enables him to assume the responsibility of
6 selecting the proper preparation, be it
7 brand-named or non-branded, in keeping with
8 his knowledge of the required character of
9 the drug and the reputation of manufacturers
10 in that particular field. His legal and
11 moral obligation should not be compromised
12 by the non-professional desires or dictates
13 of others. Recognizing that no two brands
14 of the same drug are necessarily the same,
15 and that non-brands are not necessarily the
16 same as brands, he must supply drugs and
17 drug preparations which, to his knowledge,
18 are unimpeachable and meeting his criterion
19 of pharmaceutical excellence.

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- 1 12. Drugs which are imported to meet the
2 needs of Canadians are not to be discouraged
3 provided that the Canadian public may have
4 continuing assurance that high standards of
5 manufacturing control, purity and sanitation
6 have not in any way been compromised and that
7 distribution is undertaken by ethical and
8 legal means to safeguard public health and
9 welfare.
- 10 13. Tariffs applied to life-saving drugs
11 should be kept to a minimum but provide for
12 the encouragement of Canadian industry.
13 Taxes on drugs, drug preparations and therapeu-
14 tic devices are a definite part of the
15 prices of same and are a direct financial
16 burden on the sick. Repeal of such taxation,
17 including the 11% Federal Sales Tax, is
18 definitely urged.
- 19 14. Hospitals and governments together pur-
20 chase over one-third of all drugs marketed
21 in Canada. Prices paid by them may be less
22 than one-third of the prices paid by the
23 retail pharmacist who purchases the same
24 drugs. Hence, it must be assumed that reve-
25 nue derived from sales to retail pharmacies
26 (and, in turn, from the private public)
27 'subsidizes' institutional prices.
- 28 15. Retail pharmacies are establishments in
29 which the rendering of professional pharma-
30 ceutical services are combined, to a greater



1 or lesser extent, with a business enterprise
2 under the managerial control of a pharmacy
3 practitioner. Annual gross sales in the
4 neighbourhood of \$75,000 are 'enjoyed' by
5 the majority, while the nationwide average
6 is shown to be approximately \$106,688. in
7 the Association's 1960 Survey. One-quarter
8 of this statistical gross revenue is derived
9 from the rendering of prescription services.
10 Thus, it is to be concluded that the availa-
11 bility of full and comprehensive drug pres-
12 cription service is made possible in our
13 communities only through its combination with
14 retail merchandising activities.

15 16. Retail pharmacies have high operating
17 and overhead expenses (28.4%) not common to
18 many retail operations and realize net
19 profits of only 5% of sales. Hours of work
20 are long and conditions under which services
21 are rendered are extremely exacting.

22 17. Retail pharmacists, because of the
23 nature of their practice, have a particular
24 individual interest in good business proce-
25 dures specifically related to matters and
26 transactions which have a general effect on
27 their particular role in the field of public
28 health and welfare. The Association is
29 charged with the responsibility of advancing
30 these interests by acting, at the government
level, on behalf of pharmacy practitioners.



1 18. A drug prescription is not an item of
2 commerce or trade, nor is it a merchandise
3 commodity. It cannot be bartered, sold or
4 traded. A prescription drug is placed in
5 the hands of a specific patient as the
6 tangible end result of a pharmaceutical
7 service ordered by a medical or dental prac-
8 titioner to meet his specific diagnosis of
9 the patient's needs.

10 19. Pricing guides, a variety of which are
11 available for the pharmacist's reference in
12 the pricing of his pharmaceutical services,
13 are not creations of modern times. In the
14 period when the great majority of prescrip-
15 tions were extemporaneously compounded, it
16 was not practical, in the busy dispensary,
17 to calculate the ingredient costs of each
18 prescription and thus was established a
19 universal practice of pricing by quantity;
20 i.e., 4 oz. mixture 75¢, 6 oz. \$1.00, 8 oz.
21 \$1.25, etc., and similarly with ointments by
22 the ounce, powders by the dozen, etc. This
23 system worked, presumably, as long as the
24 ingredient cost was relatively minor. Then,
25 with more specialties assuming a larger pro-
26 portion of the total number of prescriptions,
27 there came the realization that ingredient
28 costs had risen to a point where prescrip-
29 tions were being handled at a loss. There
30 ensued a period of miscellaneous pricing



1 methods almost devoid of system, bringing
2 forth many troublesome situations which
3 caused both teaching colleges and associa-
4 tions to advocate a more consistent approach.
5 It was then that the manufacturer's list
6 price came into the picture, as they are at
7 the present time, as the basis upon which
8 drug prescriptions, the complete pharmaceu-
9 tical services, are priced.

10 Pricing guides in existence in Canada refer
11 only to professional fees. They incorporate
12 manufacturers' list prices as the one conve-
13 nient figure by which the individual phar-
14 macy practitioner may adjudicate the basic
15 essential operating expense return required
16 by his business undertaking (or that of his
17 business owners or partners). Usually,
18 pricing extensions in chart form are included
19 to facilitate and expedite price calculations.
20 Prescription pricing guides exist for the
21 convenience of pharmacy practitioners who
22 may or may not use any one of them except as
23 contractual agreements may exist with govern-
24 mental or other insuring agencies. Associa-
25 tions believe that such guides merit the
26 consideration of individual pharmacists in
27 that they believe them to be based on sound
28 economic reasoning and provide charts of pre-
29 calculated figures which can serve to expe-
30 dite the rendering of services. No element



1 of compulsion is related to their private
2 use.

3 20. The patient receives the personalized
4 service of the pharmacy practitioner in
5 convenient community locations. The pharma-
6 cist carries a substantial financial invest-
7 ment in education, physical facilities and
8 inventory to meet the day-to-day requirements
9 and the emergency needs of the community.
10 From his pharmacy practice and his more
11 general business activities he is able to
12 realize a profit of only 5% which is, it
13 must be conceded, a very minor return for
14 services provided, and which is a very minor
15 portion of the overall cost of drugs.

16 THE CHAIRMAN: That is the point that you
17 were referring to at the beginning of the hearing this
18 morning?

19 MR. TURNBULL: Yes sir.

20 THE CHAIRMAN: Do you want to modify that
21 at all at this stage?

22 MR. TURNBULL: No, I think our relationship
23 here is all right, but it was the relationship in the other
24 sentence that was definitely erroneous, as Mr. Whiteley
25 pointed out.

26 THE CHAIRMAN: It still says, "A profit of
27 only 5% which is, it must be conceded, a very minor return
28 for services provided, and which is a very minor portion of
29 the overall cost of drugs".

30 MR. TURNBULL: Do you mean, should we add



1 the words "of only 5% of gross sales"?

2 THE CHAIRMAN: That is what it is referring
3 to, 5% of sales?

4 MR. TURNBULL: Yes.

5 THE CHAIRMAN: It is not 5% of capital,
6 because you have not got the figure for capital.

7 MR. TURNBULL: No.

8 THE CHAIRMAN: There are industries or
9 businesses in which 5% return on sales would be very good
10 indeed.

11 MR. TURNBULL: Oh yes.

12 THE CHAIRMAN: I think our grocery people
13 tell us they get 2% or 2½%.

14 MR. FRAWLEY: And such things as soap and
15 washing compounds.

16 MR. TURNBULL: Yes, their gross sales are
17 a little bit in excess of \$106,000.

18 THE CHAIRMAN: Yes, but we are talking about
19 profits in terms of services rendered, not profit on the
20 investment. However, we understand the way it is, and
21 that is all right.

22 MR. TURNBULL: "Only 5% of gross sales",
23 if we could inject that.

24 THE CHAIRMAN: All right.

25 MR. TURNBULL: 21. It is totally unrealistic
26 to compare the cost of drugs to the patient
27 of even a decade ago to the price encoun-
28 tered by those who must procure drugs today.
29 The drugs, themselves, have changed with
30 advances in medical and pharmaceutical



1 research. We have stated in this brief that
2 the average prescription price has increased
3 from \$1.68 in 1951 to \$3.06 in 1960 (page
4 84). We emphasize here that the composition
5 of prescriptions in these two years is sub-
6 stantially different. The increase in ave-
7 rage prices over the period, then, reflects
8 less the inflationary trends in the price of
9 a specific drug and more the introduction of
10 new medicinal substances which have become
11 increasingly complex and intricate in manu-
12 facture.

13 To compare the cost of the horse and buggy
14 of another era with the cost of a modern
15 automobile would lead to the conclusion that
16 the automobile is an extremely expensive
17 conveyance. However, on examining the total
18 cost of transportation by these two methods,
19 many considerations make the modern automo-
20 bile a much less expensive way to reach a
21 destination.

22 So it is with prescription medication. The
23 modern prescription is indeed a bargain.

24 22. In this brief, we have mentioned that
25 the per capita cost of prescription medica-
26 tion was \$7.36 in 1960 in Canada. We do not
27 believe that this can in any way be consi-
28 dered high. However, the Canadian Pharmaceu-
29 tical Association recognizes the fact that
30 average prescription expenditures mean little



1 to individuals and groups who are burdened
2 with conditions which require prescription
3 expenditures far in excess of this average.
4 For such persons, the cost of prescriptions
5 may indeed be high, especially when combined
6 with limited earning ability.

7 The pharmacists of Canada believe that the
8 cost of medication of such individuals and
9 groups constitutes a social problem about
10 which humanitarianism, generally, and profes-
11 sional pharmaceutical attitudes, specifi-
12 cally, must find an answer. To this end,
13 the C.Ph.A. is currently endeavouring to
14 measure this problem and will be presenting
15 its conclusions to the Royal Commission on
16 Health Matters.

17 23. There have been claims and this Commis-
18 sion has repeatedly heard statements which
19 indicate that drug prices in Canada are
20 higher than those in the U.S.A. In this
21 context it is interesting to note that the
22 average prescription price in the U.S.A.,
23 as determined in surveys conducted by The
24 Lilly Digest, has been consistently higher
25 than the Canadian average:

<u>Year</u>	<u>U.S.</u>	<u>Canadian</u>
1960	\$ 3.19	\$ 3.06
1959	3.09	2.98
1958	2.96	2.78
1957	2.85	2.61



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	<u>Year</u>	<u>U.S.</u>	<u>Canadian</u>
2	1956	\$ 2.62	\$ 2.49
3	1955	2.46	2.26

4 THE CHAIRMAN: Of course you have not
5 compared these in terms of man-hours of work required to
6 obtain the prescription. You used that with regard to
7 some other figures earlier.

8 MR. TURNBULL: Yes, but that information
9 relative to the American - oh, I see what you mean, the
10 man-hours and the cost of living.

11 THE CHAIRMAN: Yes. If it costs \$3.06 in
12 1960, Canadian, and \$3.19, United States, it would take
13 a Canadian longer to earn the \$3.06 than it takes the
14 American to earn \$3.19

15 MR. TURNBULL: No, no attempt has been
16 made to try and figure out the relative value of the
17 Canadian dollar as opposed to the American dollar in this
18 case, and we know the figures have changed in that five-
19 year period.

20 24. A study of the practice of Pharmacy
21 and the distribution of drugs is a complex
22 and far-reaching subject. In order that
23 the Commission may have ready access to
24 information which outlines these complexi-
25 ties, the Association is pleased to include
26 with its Brief, as an exhibit, a copy of
27 The Canadian Pharmaceutical Journal,
28 September, 1960, which contains the Sympo-
29 sium on Pharmacy and Drug Distribution
30 conducted in conjunction with our annual



1 meeting in Saskatoon in August, 1960.

2 Before presenting the concluding remarks,
3 the Canadian Pharmaceutical Association would like to
4 record its agreement with the concluding statement presen-
5 ted in the brief of the Canadian Pharmaceutical Manufac-
6 turers' Association before this Commission, expressing
7 the belief that the final report of the Commission be
8 couched in precise and fair language, so that no uninten-
9 ded allegations may be ascribed to it.

10 Many of the recent criticisms levelled at
11 the profession of pharmacy have been based on ignorance
12 of its duties, obligations, responsibilities, and the
13 functions assumed by pharmacy in all fields of endeavour.

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1 MR. TURNBULL: Many of the criticisms have
2 been based on incorrect interpretation of fact and distor-
3 tion of fact. Unfortunately it is much more difficult to
4 refute these statements once they have circulated than
5 it is to make such statements.

6 It is the sincere hope of the Canadian
7 Pharmaceutical Association that this brief will help to
8 place the role of Canadian pharmacies in its proper
9 prospective, and will thus provide the people of Canada
10 with factual documentation against which any further un-
11 informed statements concerning our profession may be judged.

12 It is the hope of the C.Ph.A. also that
13 the final report of this commission will contain a factual
14 and documented analysis of the profession of pharmacy which
15 will serve to form a basis for public opinion and which will
16 not give rise to any further unintended but harmful
17 allegations.

18 CONCLUDING REMARKS

19 The purpose and aim of an association, be
20 it oriented to a profession or trade, is to deal with all
21 questions of general application in the branch of endeavour,
22 industry or commerce, which it serves and so develop its
23 field that the enterprises in it may be conducted with the
24 greatest efficiency and economy. Such a program is the
25 general objective of the Canadian Pharmaceutical Association
26 which might be described as a non-profit organization of all
27 registered pharmacists in Canada, formed to assist its
28 members, their profession and business, in dealing with
29 mutual problems in areas such as administrative practices,
30 business ethics, commercial statistical research, relations



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1 with the Federal Government and the general public, while
2 promoting the enhancement of professional activity so that
3 all may generally benefit.

4 In its endeavours within the areas of
5 activity and the objectives outlined above, the Association,
6 quite naturally, restricts itself to recommendations and
7 advice. Its guidance is extended without any element of
8 compulsion or discipline or interference with the individual.
9 Its activities are undertaken in keeping with the dictates
10 of the spirit of majority expressions of thought.

11 The pharmacy practitioners of Canada provide
12 a comprehensive standby service. Pharmacy practice does
13 not merely provide for immediate needs, but is available
14 to render emergency services which may be required by the
15 health community. The pharmacists may enjoy a certain
16 statutory exclusiveness in the distribution of drugs, but,
17 it is emphasized, this is not the privilege of the pharma-
18 cist; rather, it is a social necessity linked with his
19 professional obligation and ability.

20 Mr. Chairman, and members of the Commission,
21 I would express the appreciation of the Association which
22 I have the honour to represent; our appreciation for the
23 privilege of appearing before the Commission, and in closing,
24 may I ask that the appendices be taken as read unless there
25 are certain appendices that you may wish to refer to and
have presented. I would ask that they be taken as read
and written into the record. Thank you, sir.

28 THE CHAIRMAN: Are you proposing to make
29 any specific comment about any of the appendices?

30 MR. TURNBULL: I will read the titles.



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1 THE CHAIRMAN: I do not think it is necessary
2 to read the titles. Are there any points you want to call
3 our attention to particularly? You may do that, or if not,
4 there may be some questions arise this afternoon.

5 MR.TURNBULL: There are no comments. I
6 believe most have been referred to in some way or another
7 within our brief, and we will be very pleased to attempt
8 to answer questions that might be directed towards them.

9 THE CHAIRMAN: I can say for the Commission
10 that in our opinion it was a very carefully and thoroughly
11 prepared brief, and we are very glad to have it presented
12 to us. We will adjourn until 2:15 at which time questions
13 may begin to be asked about your brief.

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15 ---Luncheon adjournment.

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1 Appendix A
2 of a Submission to the
3 Restrictive Trade Practices
4 Commission by The Canadian
5 Pharmaceutical Association,
6 October, 1961

5 PHARMACY ORGANIZATIONS IN CANADA

6 Introduction

7 The association of the Restrictive Trade
8 Practices Commission with the profession of pharmacy has
9 to date been chiefly with the Canadian Pharmaceutical As-
10 sociation and with certain provincial associations. Other
11 organized pharmacy groups may be presenting submissions to
12 the Commission. The purpose of this statement is to brief-
13 ly describe the nature and purpose of the various pharmaceu-
14 tical organizations and their relationship to the Canadian
15 Pharmaceutical Association. More information, including
16 the names of officers and addresses of these organizations
17 will be made available if required by the Commission.

18 Provincial Statutory Pharmacy Organizations

19 As with other fields of health care, the
20 control of pharmacy is vested in the provincial governments.
21 All provinces have enacted legislation authorizing the es-
22 tablishment of provincial pharmaceutical organizations em-
23 powered to license those who may practise pharmacy in the
24 province, set and collect fees, control and discipline their
25 own members, and to regulate the conditions under which
26 pharmacy may be practised including the dispensing and sale
27 of drugs and medicines in the respective provinces. These
28 organizations, established as associations, societies or
29 colleges with the above statutory obligations by provincial
30 legislation, are referred to as statutory pharmacy organ-
 izations.



1 The Canadian Pharmaceutical Association

2 The Canadian Pharmaceutical Association
3 is a federation of provincial statutory organizations.
4 The objects stated on its Charter are: (a) To advance the
5 science and practice of pharmacy; (b) To promote and pro-
6 tect the commercial interests of the members; (c) To pro-
7 mote the mutual interests of its associations, societies
8 and colleges, and their members; and (d) To bring together
9 their members in professional, commercial and social
10 gatherings.

11 All individual members of provincial stat-
12 utory organizations are members of the Canadian Pharmaceu-
13 tical Association. However, recently, the Quebec College
14 of Pharmacists has given notice of withdrawing as a con-
15 stituent-member of the Association. Because the constit-
16 ution of the Association requires twelve months' notice
17 of withdrawal, Quebec pharmacists are technically members
18 until June 30, 1962. Notwithstanding this, the College of
19 Pharmacists of the Province of Quebec considers itself not
20 to be affiliated with the Canadian Pharmaceutical Associa-
21 tion at the present time and may, therefore, not wish to
22 be party to this submission.

23 The Canadian Pharmaceutical Association is
24 governed by a Council composed of four representatives of
25 each provincial statutory organization. In each case,
26 two of these are appointed on the recommendation of the
27 commercial pharmacy organization in that province.
28 In addition, one representative from each of the following
29 organizations is seated on Council.

30 The Canadian Conference of Pharmaceutical



1 Faculties

2 The Canadian Society of Hospital Pharma-
3 cists

4 The Section of Industrial Pharmacists of
5 the C.Ph.A.

6 The Canadian Pharmaceutical Association
7 has no authority to impose its decisions on the various
8 constituent statutory organizations who retain complete
9 responsibility for the profession in their respective
10 provinces.

11 The Canadian Conference of Pharmaceutical Faculties

12 The Conference is an organization of mem-
13 ber-faculties of the various schools, faculties and col-
14 leges of pharmacy, there being eight, in Canada. The
15 purpose of this organization is to deal with all phases of
16 pharmaceutical education in Canada. Its organization, in
17 1944, was promoted by the Canadian Pharmaceutical Associa-
18 tion as an extension of its former Committee on Education.

19 The Canadian Society of Hospital Pharmacists

20 The Society is a voluntary organization of
21 Canadian hospital pharmacists with the object of improving
22 the standards of practice of pharmacy in hospitals.
23 Branches of the Society, which are responsible to the
24 national council, are organized in most provinces.

25 Membership in the Society is limited to
26 those pharmacists who practise their profession in hospit-
27 als.

28 Section of Industrial Pharmacists

29 The C.Ph.A. Section of Industrial Phar-
30 macists, formed in 1958, is a voluntary national organiz-



1 ation of pharmacists employed in the Canadian pharmaceu-
2 tical industry. Membership is limited to individual phar-
3 macists employed in industry who are members of the Canad-
4 ian Pharmaceutical Association. The Section is the latest
5 Canadian national pharmacy group to be organized and is in
6 the process of writing suitable objectives and regulations.
7 For the sake of clarity, it should be noted that the Sec-
8 tion bears no relationship to the Canadian Pharmaceutical
9 Manufacturers Association which has as its members certain
10 companies engaged in the pharmaceutical industry.

11 Other National Pharmacy Organizations

12 In addition to the organizations represent-
13 ed on Council, which have just been described, several na-
14 tional pharmacy organizations of a highly specialized
15 nature are closely associated with the Canadian Pharmaceu-
16 tical Association.

17 a) The Conference of Pharmacy Registrars
18 of Canada first met in August, 1956, and is an organization
19 of the registrars of the various provincial statutory phar-
20 macy organizations which meets annually to consider admin-
21 istrative problems of mutual interest.

22 b) The Canadian Foundation for the Advance-
23 ment of Pharmacy--an organization of individual pharmacists
24 and of corporate members with the object of providing fin-
25ancial support for Canadian pharmaceutical education and
26 research. This is effected by means of grants to faculties
27 and by scholarships, bursaries and loans to individual
28 students. It was founded in 1945.

29 c) The Canadian Academy of the History of
30 Pharmacy



1 An organization of individual pharmacists,
2 non-pharmacists, and corporate members with the object of
3 advancing interest in the history of pharmacy in Canada by
4 encouraging research studies, the distribution of papers,
5 the collection of items of historical interest and value,
6 and such similar projects. Its founding in 1955 was pro-
7 moted by the C.Ph.A. Committee on History.

8 Other Provincial and District Pharmacy Organizations

9 In each province there are voluntary organ-
10 izations of retail pharmacists which devote their attention
11 to matters pertaining to the commercial aspects of the re-
12 tail practice of pharmacy and common business interests.

13 In addition, district and local voluntary
14 organizations of pharmacists may exist and may be affiliat-
15 ed either directly or indirectly with the provincial vol-
16 untary organizations.

17 Although these voluntary organizations are
18 not directly affiliated with the Canadian Pharmaceutical
19 Association, the individual members of such organizations
20 are members of the Association by virtue of their regis-
21 tration with the provincial statutory pharmacy organization.

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Appendix B

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of a Submission to the Restrictive Trade Practices Commission by the Canadian Pharmaceutical Association, October, 1961

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TERMS OF REFERENCE OF C.P.H.A. COMMITTEES

6
7 Introduction --So that it may be more clearly aware of the scope of activity of the Canadian Pharmaceutical Association, the guiding terms of reference of the Association's committees are presented here for the information of the Restrictive Trade Practices Commissions. It is pointed out that these terms, as presented below, are those written for consideration and approval of the Association's Council but to date, pending further study, such approval has not been signified.

16
17 1. Publishing Committee: This Committee will concern itself with editorial and advertising policy and with the administration of the Canadian Pharmaceutical Journal and all other publications of the Association. The Committee will review the Editor's report for presentation to the Council and will study and make recommendations to Council on all proposals for new publications.

26
27 2. Finance Committee: It shall be the duty of this Committee to scrutinize the financial operation of the Association, including its Publishing Department, to prepare the annual budget, and to make all

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necessary recommendations concerning
finances to the Council.

3. Merchandising Committee: This committee
shall study and make recommendations in its
report to Council on all matters relevant
to the commercial aspects of retail phar-
macy in the realm of distribution, merchan-
dising, advertising, etc.

4. Bylaws Committee: This Committee shall
have the responsibility of supervising,
drafting and making the necessary

recommendations to Council relative to
Bylaws of C.Ph.A., the drafting of terms of
references for committees, and also super-
vise various contemplated bylaws or modif-
ications thereof of affiliated national
bodies to ensure that same are in accord
with C.Ph.A. statutes and regulations.

(a) Sub-Committee on Policy Planning: This
sub-committee will report to Council
through the Bylaws Committee on all
matters of policy concerning C.Ph.A.
and Pharmacy in general, in accord
with its extensive terms of reference
adopted at the 1958 (Edmonton) Annual
Meeting.

6. Government Liaison Committee

(1) Sub-Committee on Legislation: This
sub-committee will review, and report
to Council through the Government Lia-
ison Committee, all matters pertaining



1 to legislation of interest to Pharmacy at
2 Federal, Provincial and Municipal levels.
3 The Committee will make recommendations to
4 Council on any proposals for new legislation
5 of interest to Pharmacy and, when directed
6 by Council to do so, will make recommendations
7 thereon to the appropriate agency,
8 either through the office of the Secretary-
9 Manager or as directed, from time to time,
10 by Council.

11 (a) Canadian Drug Advisory Committee ap-
12 pointees are requested to act in liaison
13 with the C.Ph.A. and to report in confidence
14 on the work of the Drug Advisory Committee.

15 2. Sub-Committee on Health Insurance: This
16 sub-committee will report to Council through
17 the Government Liaison Committee, and make
18 recommendations on all matters, and legis-
19 lation, (Federal or Provincial) concerning
20 Health Insurance in any or all its phases,
21 and will study various possible alternatives
22 which might be in the interest of Pharmacy.
23 Where applicable, the sub-committee shall
24 work in co-ordination with the Pharmaceut-
25 ical Economics Committee.

26 (3) Sub-Committee on Emergency Measures
27 Organization: This sub-committee will
28 report to Council through the Government
29 Liaison Committee, make recommendations, and
30 act as the liaison committee of C.Ph.A. with



1 appropriate government departments on all
2 matters relating to Pharmacy and Civil De-
3 fence and the Emergency Measures Organiza-
4 tion.

5 7. Public Relations Committee: It is the
6 responsibility of the Committee to review,
7 assess, and make recommendations to Council
8 on all matters pertaining to Pharmacy in
9 relation to the public, the press, and other
10 communications media. It will devise pub-
11 lic relations projects suitable for imple-
12 mentation on a national scale.

13 (1) Sub-Committee on History: This sub-
14 committee shall report to Council through
15 the Public Relations Committee, and shall
16 concern itself with the task of gathering
17 and collating information concerning

18 the history of Canadian Pharmacy in
19 all its aspects, at all levels of the
20 Canadian community. It shall also have the
21 responsibility of collecting objects of in-
22 terest for a museum of Canadian Pharmacy.
23 It shall study and make recommendations re-
24 lated to special honour awards and mem-
25 berships. It will act as the C.Ph.A. liaison
26 body with the Canadian Academy of the
27 History of Pharmacy.

28 (2) Sub-Committee on Pharmacy Week: This
29 sub-committee will report to Council through
30 the Public Relations Committee, and be char-



1 ged with organizing and co-ordinating of
2 provincial efforts for Pharmacy Week. It
3 will gather, collate and distribute via the
4 C.Ph.A. office, information about Pharmacy
5 Week to all interested associations. This
6 sub-committee will also direct itself to
7 devising and bringing forward new programs
8 for Pharmacy Week participation.

9 (3) Sub-Committee on Vocational Guidance:

10 This sub-committee will report to Council
11 through the Public Relations Committee. It
12 will act as the liaison committee for C.Ph.
13 A. with other organizations similarly int-
14 erested, such as the Canadian Foundation
15 for the Advancement of Pharmacy, the Can-
16 adian Conference of Pharmaceutical Faculties,
17 provincial and local associations, etc. It
18 will gather, collate, distribute via the
19 C.Ph.A. office, all information, plans,
20 suggestions, to all interested bodies.

21 8. Professional Relations Committee:

22 (1) Sub-Committee on Interprofessional
23 Relations:

24 This sub-committee will report to Council
25 through the Professional Relations Commit-
26 tee, and will deal with problems or matters
27 of mutual interest to Pharmacy and other
28 professions, as well as joint projects to
29 be undertaken by Pharmacy and members of
30 allied health professions, at the national
level. This Committee will also collect



1 and make available for study, information
2 on activities at the provincial level.

3 (2) Sub-Committee on Intraprofessional
4 Relations:

5 (a) Study re Pharmaceutical Standards:

6 This study group shall report to Council
7 through the Professional Relations Commit-
8 tee, and is concerned with the code of
9 ethics and the drafting of a code of min-
10 imum standards for pharmacy at its various
11 levels re:

12 Retail (prescription department, employee
13 training, equipment, books of reference,
14 etc.); Hospital (Pharmacy and its various
15 departments); Industrial (quality control,
16 promotional practices, etc.); Organizational
17 (associations).

18 (b) Study re Pharmacists in Government
19 Services: This study group reports
20 to Council through the Professional Rel-
21 ations Committee, acts as liaison for C.
22 Ph.A. with various governmental departments
23 and professional bodies on this question.
24 It is charged with the responsibility of
25 bringing to a successful conclusion the
26 problem of obtaining for pharmacists and
27 Pharmacy a better recognition of profes-
28 sional status and public service areas.

29 9. Pharmaceutical Economics Committee:

30 (1) Sub-Committee on Pricing Methods: This



1 sub-committee will study and report to
2 Council, through the Pharmaceutical Econ-
3 omics Committee, on all matters pertaining
4 to professional fees and prescription pric-
5 ing. This Committee also will study and
6 make recommendations concerning the need for
7 the preparation of a professional fee guide
8 at the national level and will work with
9 the Health Insurance Committee in such
10 matters.

11 (2) Sub-Committee on Inter-Trade Policies:

12 This sub-committee will study and report to
13 Council, through the Pharmaceutical Econ-
14 omics Committee, on all matters relative
15 to the intertrade relationships of partic-
16 ular concern to retail and hospital phar-
17 macy (e.g., distribution policies and me-
18 thods, discounts, price habits, etc.). It
19 will also be this Committee's responsibil-
20 ity to maintain close contact with the C.
21 Ph.A.-C.P.M.A. Liaison Committee, and other
22 such trade liaison committees.

23 (3) Sub-Committee on Surveys: This sub-
24 committee shall report to Council via the
25 Pharmaceutical Economics Committee on rec-
26 ommendations and findings of such surveys
27 as may be deemed necessary: (a) Retail
28 operations; (b) Manpower needs.

29 10. Building Committee: Makes recommend-
30 ations to Council, and implements Council's



1 decisions re: (1) Future fund raising
2 campaigns for the building of the Canadian
3 Institute of Pharmacy; (2) Construction,
4 furnishing and equipping the Canadian In-
5 stitute of Pharmacy; (3) Administration of
6 the Canadian Institute of Pharmacy.

7 (a) Advisory Sub-Committee

8 (b) Provincial Advisory Members: Report
9 to Council via Building Committee and act
10 in advisory capacity with Building Committee
11 on questions relevant to fund raising, con-
12 struction and equipping the Canadian In-
13 stitute of Pharmacy.

14 11. The Pharmacy Examining Board of Canada
15 Organizational Committee: This committee
16 will report to Council and is charged with
17 the responsibility of establishing a Nat-
18 ional Examining Board, which will truly
19 represent the viewpoints of all Provincial
20 Statutory Pharmaceutical Associations.

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Appendix C

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of a Submission to the Restrictive Trade Practices Commission by the Canadian Pharmaceutical Association, October, 1961

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PHARMACEUTICAL EDUCATION IN CANADA

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Pharmacy is an ancient profession--not, in modern times always treated as a profession. The fact that it is customarily practised as a part of a retail business establishment brought about certain conflicts between scientific requirements, professional ethics, and the desire in fact, the need---to make a profit.

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From the beginning of Canadian Pharmacy the pharmacist--or druggist, as he was more commonly known--has engaged in merchandising of a variety of related commodities. There is no question that the manifold merchandising activities in which most pharmacists engage today are honorable and that the function of distribution is as important as any other in the economy of our society. As a consequence, and because only in a minority of businesses has commerce in medicinals been sufficient for the successful maintenance of a strictly professional pharmacy, the drug store has evolved, under the conditions of a free enterprise economy, to its present stage. In modern times, the range of its commercial undertakings has been extended within variable limits but with a concurrent effort to always provide necessary professional service to its community.

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Scientific progress and economic changes during these post-war years are serving both to expand and to rearrange the structure of pharmacy. The individual



1 pharmacist has gradually become less a compounder of
2 medicinals and more a scientific purveyor and technical
3 advisor. Specialization in various phases of pharmacy has
4 increased as has specialization in many other technical and
5 professional activities. Obsolete medicaments and methods
6 have given way to the new. With these changes the scope
7 of scientific knowledge required by the pharmacist has
8 expanded, and his opportunities for application of profes-
9 sional abilities have increased in number, though changed
10 in form.

11 During the present century, education for
12 the profession of pharmacy has evolved from what was essen-
13 tially an apprenticeship system to a condition of academic
14 professionalism characterized by an increasing tendency to
15 treat the study of pharmacy as an academic discipline, and
16 a growing conviction that the non-professional studies are
17 an essential part of the preparation of the pharmacist.
18 Historically, the first formalized pharmaceutical education
19 in Canada might be said to have commenced about the time
20 of Confederation. In 1871 the Ontario Legislature approved
21 the Pharmacy Act which empowered the Ontario College of
22 Pharmacy to examine candidates for license to practice
23 pharmacy in Ontario. A teaching college was established in
24 1882 and in 1892 the college was affiliated with the Un-
25 iversity of Toronto.

26 The above might be cited as indicative of
27 the evolution of pharmaceutical education, for as the prov-
28 inces or territories were formally constituted each of
29 them established their respective pharmaceutical associat-
30 ions who were responsible for the licensing and educational



1 qualification of their pharmaceutical practitioners. As
2 the provinces developed and the demand for pharmacists, as
3 well as pharmaceutical education increased, the universi-
4 ties of the provinces were approached, first to assist the
5 licensing bodies in the educational program and ultimately
6 to assume the responsibility for all of the theoretical
7 education. Today there are eight Colleges, or Schools of
8 Pharmacy, in Canada, one in each of the provinces of Brit-
9 ish Columbia to Ontario, two in Quebec and one for the
10 Maritime Provinces. In each instance they are established
11 within a university. The degree awarded is that of Bach-
12 elor of Science in Pharmacy.

13 The need for some co-ordination of pharm-
14 aceutical education in the various provinces of Canada had
15 been recognized from the outset. The agenda of the first
16 meeting of the Canadian Pharmaceutical Association of 1908
17 included 'Uniformity of Pharmacy Acts and Raising Standards
18 of Education', both of which objectives must have presumed
19 interprovincial co-operation on the part of teaching in-
20 stitutions.

21 For many years following, the desirability
22 of holding conferences of representatives of various facul-
23 ties of pharmacy was frequently discussed by the Canadian
24 Pharmaceutical Association. The first major step in this
25 direction was taken by the heads of the schools in the
26 three prairie provinces who held a series of informal dis-
27 cussions between 1917-1921.

28 The urgency for some co-ordination of effort
29 continued to grow with the changing conditions evolving as
30 the result of the rapid advances in pharmacy, medicine and



1 chemistry. The demand for highly trained graduates could
2 not be met by the existing educational standards.

3 It remained until August of 1944 when the
4 Canadian Pharmaceutical Association under its reorganization
5 brought together representatives of each college of Phar-
6 macy to make definite recommendations to the national body
7 regarding advancement of pharmaceutical education in Canada.
8 This organization was to be known as the Canadian Conference
9 of Pharmaceutical Faculties and was to play a major role
10 in the establishing of a uniform curriculum in pharmacy as
11 it exists today.

12 At the Conference's inaugural meeting the
13 following resolution was adopted: "That a minimum college
14 course of three full academic years beyond senior matric-
15 ulation leading to the degree of Bachelor of Science in
16 Pharmacy be required to qualify for the license to practice
17 retail pharmacy." A curriculum committee was named to out-
18 line the course of study which should be covered in these
19 three years.

20 After some six years of study by the con-
21 ference the 1950 meeting approved unanimously a minimum
22 basic three-year curriculum, based on either five years
23 of secondary school education or four years secondary
24 education plus one year of study in Arts and Science at a
25 university. The committee emphasized the point that this
26 program is equivalent to a four-year university pass course
27 following junior matriculation. (4 years high school). The
28 reason for the long delay in arriving at a standard curric-
29 ulum was the desire to have unanimous acceptance. It was
30 never intended that such represent a complete curriculum or



1 a permanent one.

2 It is of further interest to note that by
3 the time of the unanimous adoption of the three year pro-
4 gramme, three of the Canadian faculties and many of the
5 U.S. Colleges of Pharmacy were already requiring a four year
6 course of studies. Consequently, each constituent member
7 of the conference was requested to suggest minimum hours
8 for a four year curriculum and the curriculum committee
9 was directed to a study of minimum requirements for a four
10 year program, which would provide for specialization in
11 retail pharmacy, hospital pharmacy, manufacturing pharmacy
12 and graduate studies.

13 In 1957 the Conference approved the follow-
14 ing recommendations of its Curriculum Committee:

15 (1) "That a date should be set for the
16 adoption of a four-year course (beyond sen-
17 ior matriculation) as the minimum require-
18 ment for granting a degree in pharmacy.

19 This recommendation is made in view of the
20 fact that this committee has expressed an-
21 nually, since 1952, the opinion that minim-
22 um standards should be laid down for a four
23 year course (beyond senior matriculation),
24 and also in view of the fact that the Can-
25 adian Pharmaceutical Association is looking
26 to us for the mechanics of implementing a
27 National Board of Examiners."

28 (2) "That the date for adoption of the
29 four-year course (beyond senior matricul-
30 ation) as the minimum requirement, for



granting a degree in pharmacy be 1960".

In 1958, the Conference further stipulated that the minimum total number of hours for the four-year programme would be thirty-two hundred hours. A course of studies meeting this stipulated minimum is now the required course for the Bachelor of Science in Pharmacy degree in Quebec, Ontario, Manitoba, Saskatchewan and British Columbia and is offered on an optional basis with the 3-year programme in Alberta. In September 1961, the course as offered at Dalhousie University will lead to a Bachelor of Science in Pharmacy degree but will not meet the Conference minimum in years or hours of study.

In general, the following may be regarded as basic considerations in the modern Pharmacy curriculum:

(1) Pharmaceutical Education is based on the proposition that pharmacy is a health profession---and this must be the guiding principle in any pharmaceutical curriculum.

(2) A Primary objective of the curriculum is to provide a minimum basic training necessary to furnish an adequate and safe pharmaceutical service to the present-day community. At the same time it must lay a proper foundation for an understanding of the technical advances that the coming years will bring.

(3) Because of the continuous changes in all phases of pharmacy and the impossibility of preparing all students so that they will be qualified to engage in all activities constituting the practice of pharmacy, no



1 perfect curriculum has or probably can
2 be formulated.

3 (4) The demand that professional men con-
4 cern themselves with the broad problems
5 of our time has brought about the realiza-
6 tion that educated citizens--largely the
7 professional people---must take an intel-
8 ligent interest in the social, political
9 and moral problems of our time. For these
10 reasons the academic program must not pro-
11 vide specialized training to the neglect
12 of education in the broader phases of life
13 and must aim to make students broad minded
14 and adaptable in their social relations.

15 The following are among the more
16 specific objectives of the academic pro-
17 gramme for Pharmacy:

18 A. Select, screen and graduate those
19 students possessing the technical abilities
20 personal character, and social outlook re-
21 quired in the practice of pharmacy.

22 B. Teach students to procure, develop,
23 prepare, preserve, standardize, test and
24 dispense substances and articles used in
25 the diagnosis, treatment, and prevention
26 of disease.

27 C. Develop the ability in students to
28 utilize properly official pharmacopoeias,
29 formularies, and other recognized reference
30 works on drugs.



1 D. Ground students in the principles and
2 practices of organizing and administering
3 a pharmacy.

4 E. Make students fully conscious of the
5 ethical and moral standards to be met by
6 the pharmacist.

7 F. Qualify students to co-operate with
8 members of the other health professions and
9 to consult with them; to furnish accurate,
10 objective and scientific information to
11 physicians and members of other health
12 professions concerning drugs and their
13 action.

14 G. Prepare students to provide profes-
15 sional services to the public appropriate
16 to the basic functions of pharmacy in its
17 role as a health profession.

18 H. Equip and stimulate students to con-
19 tribute to the profession by participating
20 at its various levels--Association activ-
21 ties, organization, education, research,
22 etc.

23 I. Provide students with an adequate
24 foundation for graduate work in the various
25 subjects of the Curriculum.

26 J. Prepare students to assume the res-
27 ponsibilities of citizenship befitting
28 professionals.

29 K. Attempt to enrich the life of the
30 students by stimulating them to greater



1 understanding and appreciation of the
2 culture, values, and problems of our
3 civilization.

5 MINIMUMS FOR A FOUR-YEAR PHARMACY COURSE

6 ENTRANCE REQUIREMENTS

7 Full Senior Matriculation, including the following sub-
8 jects:

9 English (or French in Quebec), Mathematics, Chemistry.

10 Alternately, some colleges of pharmacy require a B.A. de-
11 gree as the entrance requirement.

12 LIBERAL ARTS CLASSES

13 English (or French) 90 hours

14 One, two, or more, liberal arts classes or non-science
15 classes required; but the particular classes selected may
16 be chosen by the student with the approval of the Faculty.
17 These classes should be selected from among: a foreign
18 language, anthropology, economics, English, fine arts, phil-
19 osophy, political science, psychology, etc. - 180 hours

20 BASIC SCIENCES:

21 Inorganic Chemistry, including general chemistry,
22 qualitative analysis, quantitative analysis. 180 hours

23 Organic Chemistry 150 hours

24 Physical Chemistry (optional)

25 Biology, including botany and zoology 180 hours
(and anatomy)

26 Physics 150 hours

27 Physiology 180 hours

28 Microbiology 90 hours

29 Biochemistry 180 hours

30 Mathematics (Calculus) (optional)



1 Mathematics (Statistics) (optional)

2 PROFESSIONAL CLASSES AND APPLIED SCIENCE CLASSES

3 (a) Pharmaceutics and Pharmacy

4 Pharmaceutics (including: introduction to pharmacy,
5 pharmaceutical calculations, pharmaceutical preparations,
6 pharmaceutical principles and processes, physical pharmacy)

7 300 hours

8 Compounding and Dispensing 180 hours

9 Advanced Pharmaceutics (optional)

10 Manufacturing Pharmacy (optional)

11 Cosmetics (optional)

12 Hospital Pharmacy (optional)

13 History of Pharmacy & Literature of Pharmacy

14 15 hours

15 Pharmaceutical Legislation (and Ethics) 30 hours

16 Selected Topics (optional)

17 (b) Pharmaceutical Chemistry

18 Inorganic Pharmaceutical Chemistry

19 Organic Pharmaceutical Chemistry 240 hours

20 Quantitative Pharmaceutical Chemistry

21 Instrumental Analysis

22 (c) Pharmacognosy

23 General Pharmacognosy 90 hours

24 Advanced Pharmacognosy (optional)

25 Biopharmacy 30 hours

26 (d) Pharmacology

27 Pharmacology 180 hours

28 Selected Topics (optional)

29 Agricultural Pharmacy, including animal and plant health;
30 pesticides (optional)



1 Advanced Pharmacology (Diseases and Remedies) (optional)

2 (e) Pharmacy Administration

3 (f) Electives for specialization in major field

4 This may include a Thesis or Memoire Hours to be deter-
mined.

5 Bibliographique

6 Total hours. (This total will be exceeded in actual cases,
7 since each of the schools will exceed the minimum require-
8 ment in several areas.) 3200 hours

9 A close examination of the above subject
10 titles will indicate that four general areas of study are
11 blended together in the Pharmacy Curriculum.

12 Physical and Biological Sciences

13 The pharmacist's concern with substances of
14 many kinds employed in modern health services makes it
15 necessary that he have extensive knowledge of chemistry and
16 some understanding of physics and mathematics. In order
17 to handle these substances properly, he must be fully
18 conversant with their chemical and physical properties and
19 reactions. Furthermore, it is the ultimate purpose of the
20 drugs the pharmacist handles to modify, accelerate, deceler-
21 ate, or inhibit the functioning of a cell, a tissue, an
22 organ, or an organism. In order that he may intelligently
23 and helpfully supply the materials to do this it is essen-
24 tial that he may know something about the physiology of
25 cells, tissues, organs, and organisms, how this is modified
26 by malnutrition or disease, and how it responds to drugs.
27 Because it is the responsibility of the pharmacist to
28 prepare dosage forms of medication which most effectively
29 present the medicinal agent, it becomes his responsibility



1 to know the pathways by which drugs may be administered
2 and the dosage form of each drug which is most suitable
3 for each pathway. Such knowledge calls for a substantial
4 study of the several biological sciences.

5 Further to this general area of study,
6 in a world of rapid change and a tremendous increase of
7 knowledge, it is essential that a professional man con-
8 tinue his education as long as he remains active in his
9 profession.

10
11 The basis of such continuing education, in so far as the
12 pharmacist is concerned, rests primarily upon his know-
13 ledge of the physical and biological sciences. Only as he
14 understands them is he in a position to comprehend the new
15 discoveries in science and the new technological procedures
16 that are invented.

17 Professional Subjects

18 The core of professional subjects to which
19 the pharmacy student must devote a major part of his study
20 centres around pharmacognosy, pharmaceutics, pharmaceutical
21 chemistry and pharmacology. In pharmacognosy, which deals
22 with the "materia medica" of modern pharmacy---the animal,
23 vegetable and chemical drugs, the fundamental principles
24 learned in botany, bacteriology, chemistry and biochemistry
25 are applied. Naturally, the student must acquire certain
26 pharmaceutical techniques which he must perform with skill
27 and dispatch. Underlying these techniques is a vast body
28 of factual information which must be well learned and
29 instantly available to him. While much of this information
30 has been evolved by pharmacists in their study and practice,



1 recent research and the application of more advanced
2 principles of physics and chemistry are becoming of in-
3 creasing significance in instruction in this area. Most
4 significant, too, is the greater emphasis being placed
5 on the study of pharmacology. As modern medication has
6 become more and more complex the opportunity and, in fact,
7 the need for pharmacies to become "clearing houses" of
8 information on medicines has been clearly recognized.
9 Consequently, pharmacists must be trained who are capable
10 of assuming the role of consultant on drugs to the phy-
11 sician and both practitioners should collaborate in eval-
12 uating claims and judging efficacy and safety of new and
13 competing medicines. The pharmacist must be an expert on
14 drugs, a source of up-to-date information that can be
15 used by the physician and much more expeditiously than
16 the overwhelming volume of modern technical literature.
17 To accomplish such a function requires an extensive know-
18 ledge of Pharmacology, and, in particular, of the struc-
19 ture-activity relationships of drugs.

20 Pharmacy Administration

21 The student who is preparing to become a
22 retail pharmacist has to acquire substantial understanding
23 of certain phases of economics and of organization and
24 management. So great are the financial risks involved
25 in establishing or acquiring and operating a pharmacy and
26 so difficult are many of the problems that have to be
27 dealt with in such a venture that only the unwary and the
28 reckless enter upon it without first having acquired a
29 knowledge of administration principles through careful
30 study and some first-hand contact. Therefore, the colleges



1 of pharmacy have an obligation to provide their students
2 with necessary training in this field. A mere smattering
3 of knowledge about the administrative aspects of pharmacy
4 is not sufficient for the pharmacist. He needs to acquire
5 knowledge of economic institutions, the flow of goods
6 from producer to consumer, the management of an enterprise
7 or establishment, the legal aspects of establishing and
8 operating a pharmacy, and the public relations of the
9 pharmacy and the pharmacist. This field should have the
10 same kind of careful study as other divisions of the
11 curriculum.

12 Also included in the area of Pharmacy
13 Administration is a group of subjects which perhaps might
14 best be described as professional orientation. Such mat-
15 ters as public health, professional communication, ethical
16 considerations, the history of pharmacy and laws and
17 regulations pertaining to pharmacy are within this scope.
18 They provide certain backgrounds of information required
19 for understanding the profession, they create an awareness
20 of various professional relationships, and they develop
21 certain professional attitudes and ideals.

22 General Education

23 Certainly not the least of the consider-
24 ations which are resulting in adjustments to the pharmacy
25 curriculum is the growing determination, on the part of
26 universities generally, that professional education should
27 not provide specialized training to the neglect of the
28 broader phases of our life. Dr. Lloyd E. Blauch, Chief
29 of Education in the Health Professions, Department of
30 Health, Education and Welfare, Washington, D.C. has stated



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1 that more and more we are coming to demand that our prof-
2 essional men shall concern themselves with the broad prob-
3 lems of our times. Indeed, he continued, we are realizing
4 that our educated citizens, and that means largely our
5 professional people, must take an intelligent interest
6 in the great social, political and moral problems of our
7 times if we are to survive as a nation.

8 Leaders of the professions are likewise
9 conscious of the fact that technical training alone is not
10 sufficient for the practice of a profession in the modern
11 world. They state that in many ways professional compet-
12 ence depends about as much on understanding the ways of
13 men and the world as it does on technical skill. They
14 think that, if a man is a specialist, it is most desirable
15 that he should also be civilized, that he should be reason-
16 able and see things in their proper perspective, that he
17 should be capable of judging and acting wisely concerning
18 the great and extensive interests of his community, his
19 country, and the world in which he has his home.

20 From the outset it was agreed, therefore,
21 that the extended curriculum should allow for greater
22 emphasis on general education than had been possible in
23 the three-year programme in order that pharmacists, in
24 common with other professionals, may contribute their
25 share of community leadership. Furthermore, there is
26 mounting evidence that points specifically to the contrib-
27 utions of liberal or non-technical subjects to the moral
28 fibre of the practitioner, to his professional creativity,
29 and to his ability to deal effectively with the day to
30 day problems which arise in his practice.



Appendix D

of a Submission to the Restrictive Trade Practices Commission by the Canadian Pharmaceutical Association, October, 1961

MANPOWER IN PHARMACY

The following embodies a study recommended to the Royal Commission on Health Services at its Preliminary Hearings held in Ottawa, September 27, 1961.

Introduction

1. Reasons for consideration of manpower
 - (i) Efficient allocation of professional resources?
 - (ii) Changing role of the retail pharmacist may necessitate changes in training.
 - (iii) Increasing need for manpower within some fields of pharmacy and a decreasing need in other fields could necessitate changes in scope of university training.
 - (iv) What is optimum number of pharmacists in each field of pharmacy which would be necessary for efficient flow of pharmaceutical services to the public?
 - (v) Are present university resources sufficient to supply future demands for pharmacists?

2. Present Status of Pharmaceutical Manpower

- (i) Census of present manpower

(a) Present employment- retail

-hospital

{ research
{ administration
}; production
{ sales

-manufacturing-



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1 (teaching
2 -university (faculty-(
3 (research
4 (students
5 (administrat-
6 (ion
7 -government service (research
8 (armed forces
9 - retired
- outside of pharmacy

(b) Flow between fields of pharmacy

- employment history

(University

1

14 (c) Training (Year of graduation
15 (Degree

17 (Province of Licens-
18 (sing
19 (Year
20 (History of Licens-
sing (if more than one)

21 (e) Personal (Age
22 (Sex
23 (Marital Status
24 (Weekly hours worked
25 (Weekly salary

26 (11) Concentration of Present Manpower

27 (a) Within each field of pharmacy
(Province



- (c) Relate (a) and (b) (hospital and retail only) to population areas, e.g., in cities, towns, urban areas of varying sizes (1961 Census data?)

(d) Relate retail and hospital pharmacist concentration to concentration of physicians if similar survey conducted on medical profession.

(e) Trends in concentration
(e.g., trend to urban stores?)

3. Adequacy of Present Manpower Situation

- (i) Present need for pharmacists in each field
 - (e.g., equilibrium position between supply and demand at present)
 - (ii) Comparison of numbers actually engaged in each field and present requirements (e.g., how short are we of immediate requirements?)
 - (iii) Estimation of wastage rates due to
 - (Marriage of females
 - (
 - (Retirement
 - (
 - (Death
 - (
 - (failure at university
 - (
 - (failure to practise after University

4. Utilization of Professional Manpower

- (1) Professional capacity of a retail pharmacist

(a) How many prescriptions is he able to fill in a normal day?

(b) Estimate of time consumed in other professional activities



- 1 ---ordering pharmaceuticals
- 2 ---keeping legal records (narcotics, etc.)
- 3 ---maintenance of dispensary equipment
- 4 ---management of professional personnel
- 5 ---supervising storage of drugs

6. B. Professional responsibilities

- 7 ---consultation on general health matters
8 with customers
- 9 ---consultation on drugs and prescriptions
10 with medical practitioners
- 11 ---keeping informed on new pharmaceuticals
12 and procedures

13 Note: Possibly best to approach this on an overall pro-
14 portionate basis-- e.g., Proportion of working hours spent
15 on professional functions. Otherwise a detailed time and
16 motion study would be necessary.

- 17 (ii) Present manpower requirements if pro-
18 fessional capacities of pharmacists were fully
19 utilized.
- 20 ---especially in urban areas

21 5. Anticipated Future Requirements

- 22 (i) Population estimates
- 23 (ii) Estimates of proportion of pharmacists
24 to population to maintain
 - 25 (a) present level
 - 26 (b) requirement level
 - 27 (c) full utilization level
- 28 for each field of pharmacy

29 (iii) Estimation of wastage factors

30 6. Future Manpower Resources



- (i) Projected university enrollment and capacity

(ii) Projected pharmacy enrolment and capacity

---consider changes in

 - (a) length of course
 - (b) curricula
 - (c) failure rate
 - (d) recruitment programs

7. Future Market for Pharmacists

---relate future requirements and projected
resources

---estimate future equilibrium condition between supply and demand for pharmacists

---estimate effects of general future trends

e.g., (i) increasing proportion
of women in pharmacy

(ii) changes in nature of various fields of pharmacy

(iii) increased opportunity
for post-graduate
studies

8. Comparisons with Other Countries

----general trends only

9. Conclusions

(1) Should professional manpower allocation between the fields of pharmacy be influenced?

If so, why should it be done, and how?

(ii) Should manpower resources in pharmacy (universities) be supported or not? How would this be accomplished?



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- e.g., (a) recruitment programs
 - (b) entrance requirements
 - (c) scope of university course
 - (d) protection policies of licensing bodies
 - (e) government grants

(iii) Should changes be made in the scope of university training for pharmacists due to

- (a) changing role of the retail pharmacist?
- (b) Changing proportions of opportunity between the fields of pharmacy?

Note: A study of this nature would require three independent surveys to supply the required information.

(i) A survey of all registered pharmacists in Canada (at present, 8,940) for basic data

(ii) A managerial opinion survey in all fields of pharmacy to provide date on professional utilization and anticipated requirements.

(iii) A survey of all university facilities for the education of pharmacists for present enrolment, anticipated enrolment and graduates' lists from which can be drawn the number of pharmacists who are not registered. Also anticipated faculty requirements could be ascertained here.



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Appendix E

of a Submission to the Restrictive Trade Practices Commission by The Canadian Pharmaceutical Association, October, 1961

CANADIAN DRUG AND PHARMACY LEGISLATION

ITS OBJECTS AND PHILOSOPHY

Before entering into a discussion of the various legislative controls which have been established to provide safe and proper distribution of drugs to the Canadian public, it would seem appropriate to briefly examine the background and evolution of such legislation.

Today we recognize clearly the distinction between the medical practitioner, whose function it is to diagnose and to prescribe treatment for illness, and the pharmacist whose role, in the broad sense, as an expert on drugs, is to be responsible for the preparation, testing, preserving, compounding and dispensing of drugs, i.e. of substances used in the diagnosis, prevention and treatment of disease. At one time, however, the same person in the community performed both functions. In some early civilizations the religious leaders combined the treatment of disease, including the preparation of crude medicines, with their religious practices. Primitive man was probably intensely superstitious, looked upon disease (which he could not understand) in fear, attributing it to evil spirits. Little wonder, then that some vestige of superstition attended man's view of disease and treatment until our understanding of both rested on a firm scientific foundation.

The separation of the compounder, or drug



1 specialist, and the prescriber could not be made until a
2 government recognized that there was need for both apothecary
3 and physician and it was in the interest of public
4 health that neither should do the work of the other. This
5 occurred in 1240 A.D. when Emperor Frederick II of Hohen-
6 staufen, Kingdom of the Two Sicilies (and Holy Roman
7 Emperor) issued a decree that created pharmacy as an
8 independent branch of a governmentally supervised health
9 service and, in so doing established a pattern that was
10 accorded almost universal application in the centuries
11 that followed. The two most significant regulations of
12 the edict were:

13 (1) The separation of pharmacy from medicine
14 -- an acknowledgement of the fact that the
15 practice of pharmacy required special know-
16 ledge, skill, initiative, and responsibility
17 if adequate care of the medicinal needs of
18 the people was to be guaranteed. By for-
19 bidding any business relation between physi-
20 cian and pharmacist, the law tried to esta-
21 blish the ethical principle that professional
22 service only, not exploitation of the sick,
23 should be the function of the healing profes-
24 sions.

25 (2) Official supervision of pharmaceutical
26 practice -- thus was acknowledged the impor-
27 tance of pharmacy as a public health service
28 for the protection of the public.

29 The establishment of a separate group of
30 compounders and sellers of drugs implied an awareness of



1 the need for medicines of more consistent uniformity.
2 Other examples of this development are to be found in both
3 France and Germany. In the town of Arles, in southern
4 France, a municipal statute, probably dating back to the
5 beginning of the 13th century, called for a separation of
6 the medical and pharmaceutical professions, provided a
7 pharmaceutical oath and forbade the management of pharma-
8 cies by physicians. In Paris an edict issued by Charles
9 VII in 1484 forbade the practice of pharmacy by spicers.
10 In Germany, the apothecaries achieved somewhat of an
11 official status through the privilegium, i.e the granting
12 of special privileges on the basis of particular duties
13 carefully stipulated in a signed and sealed document,
14 carrying full legal power. Such a contract, which was a
15 typical product of the feudal system, and especially pecu-
16 liar to Germany, was bestowed upon apothecaries by an indi-
17 vidual ruler or by an aristocratic governing body of a
18 principality.

19 Naturally, in England as well as on the
20 continent, there were early dealers in drugs. During the
21 Middle Ages, the English trade in drugs was largely in the
22 hands of a guild of pepperers who received supplies through
23 the port of London. In 1328 the pepperers adopted the
24 name grossaril (dealers in gross) and received official
25 recognition as the body that had the regulating of weighing
26 in the City of London. Eventually, the guild adopted the
27 title of Company of Grocers and under this name received a
28 charter from King Henry VI in 1428. Historical records
29 indicate that the pepperers, spicers and apothecaries
30 were originally branches of this same guild with the latter



1 interesting themselves more in dealing in drugs for
2 medicinal use. In due course the apothecaries achieved
3 a measure of independence through the granting, in 1617,
4 by James I of a charter, establishing the Society of the
5 Apothecaries of the City of London. In answer to a
6 protest on the part of the grocers James I replied:
7 "Grocers are but merchants; the business of the apothecary
8 is a mystery; wherefore, I think it fitting that they
9 should be a corporation of themselves".

10 It is a matter of record that many of the
11 early apothecaries in England were Frenchmen, some of
12 whom also had passed examinations in medicine and there-
13 fore were entitled to practice both professions. Whether
14 or not because of the pattern established by these men,
15 the apothecaries in England tended to become a group of
16 minor medical practitioners, specializing in the prepara-
17 tion and compounding of drugs. Thus it was that, over a
18 period of time, the apothecaries allowed their special
19 privileges as preparers of drugs to be usurped by a new
20 group of chemists and druggists. By the end of the 18th
21 century this new group had absorbed a considerable propor-
22 tion of the sale of drugs and medicines, and after the
23 first few years of the 19th century, had practically
24 monopolized it. It then was the chemists and druggists
25 who in 1841 formed the Pharmaceutical Society of Great
26 Britain and, in 1843, received a charter of incorporation
27 which gave them the power to regulate the education and
28 admission of members.

29 The stage was now set for legislative
30 control over the practice of pharmacy and at a time when



1 there was growing concern over the large number of fatal
2 cases of poisoning occurring annually. The matter was
3 referred by the government to the Pharmaceutical Society
4 and the members were circularized in order to obtain
5 particulars as to the conditions pertaining to the sale
6 of poisons, and especially arsenic, in various parts of
7 the country. This desire to protect the public health
8 led first to the relatively ineffective Arsenic Act of
9 1851 and the Pharmacy Acts of 1852 and 1868. This latter
10 act made it an offence for persons not registered by the
11 Society to keep open shop for the retailing, dispensing
12 and compounding of certain substances that were scheduled
13 as poisons.

14 The status of the pharmacist as a specialist
15 in drugs received further clarification in Great Britain
16 through the National Insurance Act of 1911. After
17 receiving representations from various quarters, Parlia-
18 ment decided that, in the interest of those receiving
19 this health service, it should be spelled out in the Act
20 that it is the physician's function to diagnose and pres-
21 cribe and that all dispensing must be under the super-
22 vision of a properly licensed pharmacist. The principle
23 was established, also, that patients were to have freedom
24 of choice in respect to the pharmacist to whom the pres-
25 cription would be submitted. As providers of this impor-
26 tant segment of the total service, pharmacists were to be
27 directly represented at the various administrative levels.

28 It was against this background of British
29 legislation that those who first became concerned with the
30 setting up of safety measures in Canada viewed the problem.



1 Although in pre-Confederation years certain preliminary
2 steps were taken, it was not until after 1867 and after
3 the B.N.A. Act clearly designated health matters as a
4 provincial responsibility that definitive action began to
5 emerge. Pharmacy Acts were passed by the legislatures in
6 Quebec and Ontario in 1870 and 1871 respectively. These
7 were followed, over a period of years, by similar action
8 in other provinces. At the present time each province in
9 Canada has its Pharmacy Act and the sale of drugs in the
10 north is covered by Chapter 16 of the Ordinances of Yukon
11 Territory - An Ordinance Respecting the Profession of
12 Pharmaceutical Chemist.

13 Federal Controls: - In very broad terms, the Federal Legis-
14 lation, which is based on the constitutional power in
15 relation to criminal law, is intended to protect the
16 consumer from health hazards and from fraud and deception
17 arising out of the sale of drugs. On the other hand,
18 Provincial legislation, which is based on the constitu-
19 tional power of the Province in respect to property and
20 civil rights, deals with such matters as who may pres-
21 cribe drugs; the qualifications, examining and licensing
22 of pharmacists; the operation of drug stores; restriction
23 and regulation of the sale of drugs generally and of the
24 sale of poisons, narcotics and prescription drugs in
25 particular; and similar matters. In relation to certain
26 aspects, the Federal and Provincial legislation overlaps.

27 At the Federal level, the three principal
28 statutes dealing with drugs are:

29 The Opium and Narcotic Drug Act (R.S.C.
30 1952, Chapter 201)



1 The Food and Drugs Act (1952-53, Chapter 38)

2 The Proprietary or Patent Medicine Act

3 (R.S.C. 1952, Chapter 220)

4 The Food and Drugs Act is the most important

5 Federal law dealing with drugs. While this legislation

6 still maintains its initial stringent controls over the

7 labelling of drugs and advertising claims made for them

8 in the interest of preventing fraud and deception, its

9 scope in relation to protecting the consumer from health

10 hazards has been continually expanded, particularly in

11 recent years. Among the factors responsible for this,

12 several are of particular significance. In the first

13 place there has been a drastic change in the complexity

14 and specificity of modern drugs with resultant tendency

15 to centralized manufacturing. The majority of these new

16 drugs are very potent substances and the results of abuse

17 can be a serious health hazard. Furthermore, inter-provin-

18 cial commerce in drugs is now very extensive. Modern

19 methods of advertising and promotion likewise do not

20 respect provincial boundaries.

21 In this connection, it is of interest to

22 note that prior to 1920 the restriction on the sale of

23 certain drugs on prescription was controlled entirely by

24 Provincial legislation. First, because of abuse and

25 illegal usage, narcotic drugs were placed under prescrip-

26 tion control and, since 1942, a further list of potent

27 drugs (now designated as Schedule F) was set up under the

28 Food and Drugs Act and the prescription requirement

29 invoked. Thus it is apparent that the pharmacist now has

30 responsibilities under both Federal and Provincial law in



1 regard to the sale of a considerable, and certainly an
2 important segment, of his stock of drugs.

3 The Proprietary or Patent Medicine Act has
4 little significance in respect to the subject of this
5 brief. Suffice to say, therefore, that it allows a manu-
6 facturer, subject to certain restrictions, to manufacture
7 and sell a medicine compounded according to a private
8 formula and registered under the Act. A proprietary or
9 patent medicine must not contain a narcotic, an excess of
10 alcohol, or a new drug or a prescription drug as defined
11 under the Food and Drugs Act. It is of interest also, to
12 observe that, since Provincial legislation normally exempts
13 products registered under the Proprietary or Patent Medi-
14 cine Act, these products may be sold through other retail
15 outlets besides drug stores.

16 Provincial Controls: - In the original Ontario Pharmacy
17 Act, enacted in 1871, which in turn served as the model
18 for the majority of the other provinces, the basic prin-
19 ciples adopted did not differ significantly from tried
20 and proven British practices.

21 Basically, provincial pharmaceutical legis-
22 lation is concerned with the qualifications to be met by
23 persons in order to practice as pharmaceutical chemists
24 (pharmacists) within the respective provinces. This
25 involves providing for the licensing board or Council, and
26 defining academic courses, examinations and apprenticeship
27 or internship requirements. The acts then proceed to
28 place on the pharmacists the responsibility for the
29 compounding, the dispensing and the sale of drugs and
30 medicines as well as responsibility for the sale of poisons.



1 This responsibility also carries with it the enjoyment
2 of the privilege of restriction of these services to
3 duly registered pharmaceutical chemists. Consequently,
4 each of these several acts provides that "except as
5 otherwise provided" no one except a pharmaceutical
6 chemist may compound or dispense prescriptions of autho-
7 rized practitioners or sell or offer for sale or keep
8 open shop for the sale, the compounding or the dispensing
9 of drugs, medicines or poisons.

10 The acts generally except legally autho-
11 rized practitioners of medicine, dentists and veterinary
12 surgeons from these provisions in respect to the supplying
13 of medicines to their own patients. These exceptions do
14 not authorize the supplying of such medicines by office
15 nurses, secretaries or other unqualified persons. Nor
16 do they authorize the supplying of medicine to patients
17 other than the practitioner's own. Respecting the
18 compounding and dispensing of medicines in hospitals,
19 eight provinces by implication or by express provision
20 require that no one except a pharmacist may perform
21 this function. In practice this necessitates an over-all
22 and continuous supervision by a pharmacist if the patient
23 in a hospital is to receive no less protection against
24 the hazards of drug use than is accorded a person who is
25 not institutionalized.

26 In summary, the objectives and philosophy
27 of Canadian legislation pertaining to drugs and of
28 standards of practice of pharmacy may be broadly stated
29 to include the following:

- 30 1. The preservation of the traditional



1 British distinction between the medical
2 practitioner, whose function is to diagnose
3 and to prescribe treatment, and the pharma-
4 cist whose role, in the broad sense, is to
5 be responsible for the preparation, testing,
6 preserving, compounding and dispensing of
7 drugs, i.e. of substances used in the diag-
8 nosis, prevention and treatment of disease.

9 2. It is not in the public interest that
10 there be direct business relationships
11 between practitioners of medicine and phar-
12 macy, on the principle that professional
13 service, not exploitation of the sick,
14 should be the main function of the healing
15 professions.

16 3. A specialized knowledge and skill is
17 necessary in the procurement, preservation
18 and distribution to the consumer of drugs
19 and such ancillary items as present any
20 health hazard.

21 4. While not wishing to unnecessarily
22 restrict the individual's right to self
23 medicate, it is recognized that those
24 substances defined as "drugs" in the Food
25 and Drugs Act, do represent a health hazard
26 and that there must be certain limitations
27 placed on their distribution in order to
28 protect the purchaser from his own ignorance
29 or from the actions of those who would use
30 his ignorance, fear, or anxiety for their



1 own gain. This latter objective is held
2 to apply equally to labelled claims and to
3 advertising and other promotional measures.

4 5. Further to the above, the necessity
5 also is recognized of restricting all
6 narcotics and certain other schedule drugs,
7 as shall be specified from time to time, to
8 sale only on the prescription of a recog-
9 nized practitioner. In this connection,
10 the patient who receives medication while
11 in a hospital, nursing home or other insti-
12 tution should receive no less degree of
13 protection than is required by law when
14 purchase is made through the ordinary retail
15 channels.

16 6. The manufacturer of a drug is required
17 to make certain that his product meets the
18 specified standards of purity and potency
19 and that it has been prepared under sanitary
20 conditions. Furthermore, he must satisfy
21 the Food and Drug Directorate prior to
22 marketing a new drug that adequate tests
23 have been performed to guarantee its safety
24 when used for the purposes claimed and
25 according to the directions given.

26 7. A considerable measure of responsibility
27 and discretionary authority is vested in
28 medical and pharmaceutical licensing bodies
29 to ensure that their practitioners conform
30 to both the legal and ethical standards in



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order that a maximum of public safety may
be maintained with a minimum of restriction
on the use of medicinal substances.

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1 Appendix F
2 of a Submission to the
3 Restrictive Trade Practices
4 Commission by The Canadian
5 Pharmaceutical Association,
6 October, 1961

7 FEDERAL ADMINISTRATION OF DRUG LEGISLATION

8 As part of its submission, dated July 15,
9 1961, to Royal Commission on Government Organization, the
10 Canadian Pharmaceutical Association made specific
11 recommendations designed to improve the administration of
12 legislation and regulations which are designed to control
13 the manufacture and distribution of drugs in Canada.
14 The pertinent sections, being Part II of that submission,
15 are extracted and presented here for the information of
16 the Restricted Trades Practices Commission.

17 * * * * *

18 Drugs, as such, are not specifically
19 mentioned in the British North America Act. Therefore,
20 proper segregation of drug legislation is difficult for
21 two reasons: first, there must be determined an appropriate
22 class of subjects which, directly or by implication, is
23 sufficiently broad in scope to include the category of
24 drugs; second, drug legislation may involve matters of
25 concern to both the federal and provincial bodies. Federal
26 legislation, as it affects drugs, is concerned primarily
27 with the protection of the public by establishing standards
28 and the prevention of fraud in the manufacture and sale
29 of drug products.

30 The necessity and significance of exercising
31 a proper regulatory control at the federal level over the
32 importing, manufacturing and distributing of drugs has
33 become more evident with the passage of years. The



1 responsibility for the administration of such controls as
2 presently exist is vested in the Department of National
3 Health and Welfare, in particular, in the Food and Drug
4 Directorate and the Division of Narcotic Control.

5 The first legislation in Canada respecting
6 food and drugs, prompted by a movement to banish impure
7 liquor, was passed in 1874. Thus, "An Act to Impose
8 License Duties on Compounders of Spirits and to Amend the
9 Act respecting Inland Revenue and to Prevent the Adultera-
10 tion of Food, Drink and Drugs" became the first statute
11 dealing with the subject on this continent. Provision
12 for the examination and analysis of drugs does not appear
13 to have come about until 1883. In 1919 the official name
14 of this "Adulteration Act", as it was commonly known,
15 became the "Food and Drugs Act". Between 1920 and 1953 a
16 number of amendments were added and in 1953 the entire
17 Act was rewritten and the subject matter presented in a
18 more orderly fashion. The Canadian Pharmaceutical
19 Association respectfully submits, in what follows, that the
20 next stage in this evolution should now be a re-organization
21 of administrative procedures and practices.

22 The first Act pertaining to the suppression
23 of opium was passed by the Parliament of Canada in 1908 and
24 made it an offence to sell, offer for sale, possess or
25 manage crude opium for other than medicinal purposes, or
26 opium prepared for smoking. By 1911, mounting concern
27 regarding the improper use of morphine, cocaine and heroin
28 resulted in further legislation to control these drugs, and
29 in 1919 the Narcotic Division of the Department of Health
30 was assigned the administration and supervision of the



1 Narcotic Act. The present Opium and Narcotic Drugs Act
2 was passed in 1929, and subsequent amendments to the Act
3 and Regulations have served to permit domestic control of
4 both legitimate and illicit narcotic traffic, and to foster
5 liaison and co-operation with other countries and world
6 organizations in mounting limitations on the manufacture, the
7 trade and consumption of narcotic drugs to insure their
8 legitimate use for medicinal and pharmaceutical purposes.

9 Speaking still of what has transpired up
10 to the present, in relation to the success of these two
11 Acts, it is our contention that while the Opium and Narcotic
12 Act has been administered in a manner that has effectively
13 controlled the legitimate manufacture and distribution of
14 narcotics, the aims and objectives of the Food and Drugs
15 Act in respect to other classes of drugs, are not being
16 achieved in a satisfactory manner. This statement is,
17 of course, a broad generalization which our Association
18 will be prepared to elaborate a greater length than is
19 possible in this presentation.

20 The Administration of the Food and Drugs Act -- The
21 Canadian Pharmaceutical Association, both through its head
22 office staff and the pharmacist members of the Canadian
23 Drug Advisory Committee of the Department of National
24 Health and Welfare, has enjoyed a close and cordial liaison
25 with the administrative staff of the Food and Drug
26 Directorate. We believe that a sincere and conscientious
27 attempt has been made to administer the Act and the
28 Regulations within the limitations of the restricted budget
29 provided for this purpose. Nevertheless, as a consequence
30 of extensive and rapid changes in both the nature and



1 composition of modern drugs and in the industry itself,
2 this effort has fallen far short of containing the situa-
3 tion. Evidence of this is seen from the fact that many
4 of the symptoms of malfunctioning in the pharmaceutical
5 industry revealed during the so-called "Kefauver
6 Investigation" in the United States also are evident in
7 Canada and of the existence of certain other problems
8 which can readily be documented. We believe that manu-
9 facturing and distributing, that weaknesses in the Act and
10 Regulations have contributed to this situation, and that
11 a re-organization of the administrative approach is a
12 primary requisite to a reversal of the deterioration.

13 It should be emphasized, at this point,
14 that our criticisms and proposals are being made with the
15 knowledge that certain changes in regulations are being
16 affected which will strengthen the controls over the
17 more dangerous barbiturate and amphetamine drugs and
18 which will require more extensive "quality control" in the
19 manufacture of drugs in general. We have supported these
20 changes wholeheartedly since we believe them to be in the
21 public interest. In our view, however, they will only
22 compound the administrative problems with which the
23 Director has been faced. Consequently, the concern which
24 the Canadian Pharmaceutical Association has long felt is
25 now heightened by the fear that the proposed amendments
26 to the regulations will fall far short of providing a
27 much needed control over either or both of these serious
28 problems.

29 Basically, in our view, the solution to
30 administrative problems in the Food and Drug Directorate



1 lies in the direction of a more clearly defined departmental
2 alization of "food" and of "drug" control. Foods and drugs
3 are both commodities of the utmost significance to public
4 welfare. Both are products of large industries representing
5 enormous investments in Canada. Both have ramifications
6 that extend into almost everyphase of our economy
7 but it also can be said that in this present century and
8 particularly since 1945, due to the scientific and
9 technical aspects involved, the drug industry has become
10 much the more complex. The time has arrived, therefore,
11 when its control should be approached with a more complete
12 understanding of scientific, technical and economic aspects.
13 In our view lack of such understanding, at all levels, is
14 a major deficiency of present administrative practices,
15 and, is a contributing factor to lack of efficiency.

16 Our views are summarized below as constructive
17 and practical recommendations urgently requiring
18 implementation.

19 1. Exclusive of the Proprietary or Patent
20 Medicine Division, the divisions of the
21 Food and Drug Directorate are the Scientific
22 Services, the Inspection Services, the
23 Administrative Services and five regional
24 divisions. We recommend that in each of
25 these divisions there be a more clear-cut
26 differentiation between the personnel
27 involved and the duties of such personnel
28 in respect to food control and to drug
29 control.

30 2. We recommend that consideration be given



1 to the establishment of either or both of
2 the following:

3 (1) In addition to the present Deputy
4 Minister (Medical) there be a Deputy Minister
5 (Pharmaceutical) -- qualifications: Ph.D.
6 degree, where undergraduate or graduate
7 training, or preferably both, has been in
8 a Pharmacy faculty.

9 (2) Either the Director or an Associate
10 Director of the Food and Drug Directorate
11 should possess qualifications as outlined
12 above.

13 3. Scientific Services: We recommend (1)
14 That the central laboratory services
15 division include, in addition to the
16 present pharmaceutical chemistry section
17 and other existing sections, a pharmaceutics
18 section and that an essential requirement
19 for technical staff in these two sections
20 be undergraduate, or preferably graduate,
21 training in a Pharmacy faculty and, further,
22 that such individuals be classified as
23 pharmacists (see part I of this brief)

24 (2) That the technical staff in each
25 regional laboratory include one or more
26 pharmacists, so classified.

27 4. Inspection Services: We recommend (1)
28 That all members of the central inspection
29 staff whose responsibilities include the
30 inspection of drug manufacturing plants have



1 at least a minimum qualification of an under-
2 graduate degree in pharmacy. (2) That
3 inspection of retail pharmacy establishments
4 at the regional level be carried out by
5 inspectors who have an undergraduate degree
6 in pharmacy. In this connection we draw
7 attention to the fact that this is the
8 policy followed in the Division of Narcotic
9 Control and that a successful record of
10 enforcement has resulted.

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Appendix G
of a submission to the
Restrictive Trade Practices
Commission by the Canadian
Pharmaceutical Association,
October, 1961.

A report to J. C. Turnbull, March 30, 1961, relative
to generic names in the "Compendium of Pharmaceutical
Specialties", prepared by Professor J. G. Nairn,
University of Toronto.

General

10 The purpose of this report was to make a
11 survey of the "Compendium of Pharmaceutical Specialties"
12 with regard to generic names. A survey of this type could
13 involve a great deal of work unless there were some
14 arbitrary restrictions imposed. The restrictions imposed
15 were; the method of classification, and the sources of
16 reference. This work was not checked for accuracy because
17 it is doubtful if the results would change very much due
18 to the large number of drug products involved.

19 || Classification

After two or three methods of classification
of the pharmaceutical products were tried, and keeping in
mind the time involved and the results to be produced, the
following method of classification was finally adopted:

24 First Division

25 a. those products which can only be used
26 in a hospital (there was no further subdivision of this
27 class).

b. those products which contain a mixture
of drugs (there was no further subdivision of this class).

c. those products which contain a single



1 drug.

2 Second Division

3 Those products which contain only a single
4 drug were split into two groups: a. a regular dosage
5 form and b. a special dosage form.

6 Third Division

7 Both the single drug regular dosage form
8 and single drug special dosage form were split into three
9 groups:

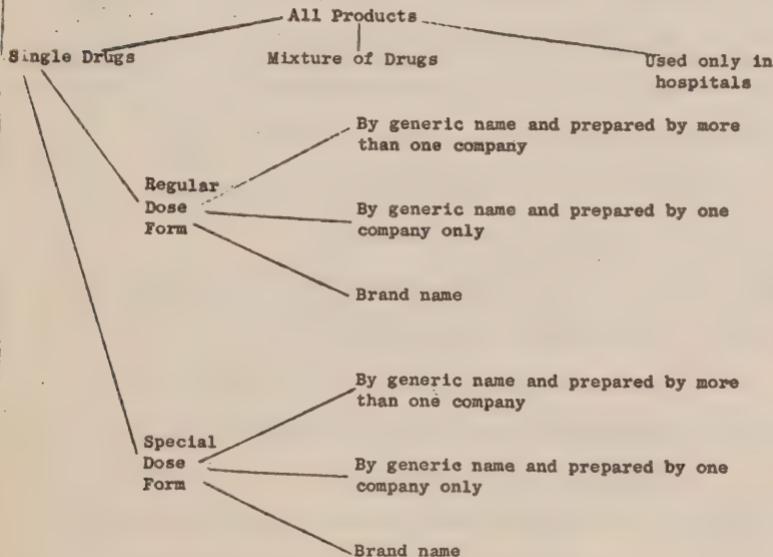
10 a. Those which could be dispensed by their
11 generic name and are made by more than one company.

12 b. Those which could be dispensed by their
13 generic name but only one company prepares the active drug.

14 c. Those which could be dispensed by
15 their brand name only.

Appendix G

CLASSIFICATION





1 Definitions

2 Hospital - products were put in this class only if they
3 could be used in a hospital. If there was any
4 doubt the product was placed in other categories.

5 Mixture - All products which contain more than two active
6 ingredients, also ointment bases containing more
7 than two ingredients. This group would not
8 include an ointment which contains only one
9 active ingredient.

10 Single drug - these products which contain a single drug
11 only. An extract of a single plant (which
12 could possibly contain more than one drug) was
13 placed in this class.

14 Special dosage form - A more or less arbitrary classifica-
15 tion where the drug was in a particular dosage
16 form, e.g. injectable suspensions, sublingual
17 tablets, modified antitoxin, specially prepared,
18 micronized, buffered preparations, flavoured,
19 compacts, specially extracted, mixed vials, per-
20 fumed, resin containing, sustained action,
21 impregnated bandage, gum, effervescent, inhaler
22 and aerosol.

23 Regular dose form - are the regular types of products one
24 would expect to find, e.g. liquids, tablets
25 and also gels, sterile preparation suspensions,
26 granules, water soluble, coloured, troches,
27 lyophylized and ointments.

28 Generic name - a non proprietary or a name that is not
29 associated with one company. It would seem
30 that patent rights to many drugs are controlled



1 by one company even though that drug has a
2 generic name. A generic name should be relatively
3 simple. For quite a few monographs the generic
4 name is given or else it could be easily ob-
5 tained from one of the references. The
6 generic name is not necessarily an official
7 name.

8 Produced by one company - if the active ingredient was
9 sold in one form or another by more than one
10 company then the drug was not placed in this
11 class.

12 Brand name - refers to products which have a long chemical
13 name and for which there is no generic name,
14 this classification also refers to products for
15 which the ingredients are not listed.

16 Product - refers to any pharmaceutical product in the
17 Compendium. If a specialty has a different
18 form or different concentration it was counted
19 as a product, however, if it was just a
20 different size, i.e. 25 tablets or 50 tablets,
21 this was not counted as another product.

22 Reference Texts

23 Compendium of Pharmaceutical Specialties (Canada 1960)

24 F. N. Hughes, Canadian Pharmaceutical Association Inc.

25 Toronto 1960.

26 Facts and Comparisons, E. K. Kastrup, Facts and Comparisons
27 Inc., St. Louis, 1958 (corrected to March 1961).

28 American Drug Index 1960, C.O. Wilson and T. E. Jones,
29 J. B. Lippincott Co., Montreal 1960.

30 New and Nonofficial Drugs, J.B. Lippincott Co., Montreal 1960



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Results

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	<u>Number</u>	<u>Per Cent</u>
Total number of products	7776	100.00
"Hospital"	85	1.09
"Mixture"	4593	59.07
"Single regular generic"	2010	25.85
"Single regular generic one company"	591	7.60
"Single regular brand"	156	2.01
"Single special generic"	277	3.56
"Single special generic one company"	55	.71
"Single special brand"	<u>9</u>	<u>.16</u>
Total	7776	100.05

15

Points to be Noticed

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1. There often is a group of drugs in the "single regular generic" class where many companies sell the same drug, e.g., Thiamine hydrochloride - 69 products; Sulfathiazole - 34 products; Vitamin B₁₂ - 26 products; Stilboestrol - 52 products. The above 2010 represent 434 different active ingredients.

23

2. A chemical name is not necessarily a generic name, only if it is relatively simple.

25

3. Sometimes only one company distributes the product in Canada and a different company in the U.S.A. Since two companies sell the product, the product was put into the "Single regular generic" class rather than in the "Single regular generic one company" class.

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4. If the active ingredient is available



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1 from more than one company then the product was put in the
2 "single regular generic" class even though a particular
3 form is available from only one company, i.e. drops or
4 tablets.

5 5. Kits of syringes or needles were placed
6 in the mixture class.

7 6. Some of the products containing more
8 than one active ingredient, i.e., mixtures, are produced
9 by more than one company.

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AA/EMT/hm 1 ---On resuming at 2.15 p.m.

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3 THE CHAIRMAN: Mr. MacLeod, are you leading
4 off this afternoon?

5 MR. MacLEOD: I understand so, sir. Perhaps,
6 Mr. Chairman, there is one point I should make before
7 starting. I think it is obvious from page 93 of the brief
8 that certain questions which I may have asked in previous
9 hearings may have been interpreted as reflecting the views
10 of the Commission, which of course is not so. The only
11 purpose of my putting questions forward is to get the views
12 of the witness, and if I ask him, for instance, if a larger
13 type of drug store would not affect the economies, it was
14 merely to get the views of the witness on that point.

15 I raise that because there is that reference
16 at page 93, and there is an earlier reference which I
17 cannot put my finger on at the moment.

18 Mr. Turnbull, on page 14, in the third
19 paragraph, you make the point "the fact that pharmacy is
20 customarily practised as a part of a retail business
21 establishment has brought about certain conflicts between
22 scientific requirements, professional ethics and the desire
23 -- indeed the need -- to make a profit".

24 On page 55 you say "seen in its entirety,
25 pharmacy is a conglomeration of diverse interests. In
26 particular, the interests of the pharmacist as a profit-
27 seeking retailer and the pharmacist as a professional technician
28 are frequently in conflict."

29 I suggest that that does support the view
30 of the Director that the Pharmaceutical Associations almost



1 of necessity do have a duality of personality. You deal
2 with that on page 97.

3 I suggest that the Director is quite correct
4 in suggesting that this duality of personality does appear
5 in the operations of the various associations.

6 MR. TURNBULL: Do you wish me to respond to
7 your suggestion?

8 MR. MacLEOD: Yes, I point out you have
9 yourself in your statement, in your brief, said virtually
10 the same thing.

11 MR. TURNBULL: Well, may I refer you to the
12 paragraph beginning on page 98, sir. We have not contested
13 that there is a duality in interests on the part of the
14 individual practitioner, and that such a duality of interests
15 also might relate to, shall we say, the majority of councillors
16 that sit at the council table of our statutory bodies, but
17 we have suggested that any dual expression of thought as
18 councillors is more superficial than they appear to those
19 outside the profession.

20 We do not deny that there could possibly be
21 a duality of interests on the part of those who sit at the
22 table.

23 MR. MacLEOD: Yes.

24 MR. TURNBULL: But we are suggesting, sir,
25 that that is where the duality of interests possibly ends.

26 MR. MacLEOD: Would it be fair to put it
27 this way: You would perhaps suggest that the Director has
28 rather overdrawn the situation? I just want to get clear
29 exactly what you mean in view of your own reference to the
30 same situation.



1 MR. TURNBULL: Yes. My answer to that
2 question could be yes. I feel that the Director's statement
3 has possibly placed a degree of, shall I call it undue
4 emphasis upon this particular subject.

5 MR. MacLEOD: On page 30 there is a reference
6 to the work of a committee under the paragraph heading
7 "points of reference". At the last meeting of the Canadian
8 Pharmaceutical Association was the question of approaching
9 manufacturers to allow a 50% discount rather than a 40%
10 discount discussed?

11 MR. TURNBULL: At the last meeting, sir?

12 MR. MacLEOD: Yes.

13 MR. TURNBULL: I would have to say a qualified
14 no to that in that I don't recall it. The minutes of that
15 particular meeting have not yet been prepared. I would
16 ask that it be a qualified no, at the last meeting.

17 MR. MacLEOD: Was it discussed at previous
18 meetings?

19 MR. TURNBULL: Yes.

20 MR. MacLEOD: Has any committee of your
21 association in fact approached the manufacturers?

22 MR. TURNBULL: No.

23 MR. MacLEOD: Is such a step under contem-
24 plation?

25 MR. TURNBULL: No.

26 MR. MacLEOD: What did the discussion that
27 took place lead to? What decision or conclusion was
28 arrived at?

29 MR. COOK: Which discussion do you mean?

30 MR. MacLEOD: The discussion that he said has



1 taken place about manufacturers allowing retailers 50%
2 rather than 40% as a discount on list price.

3 MR. TURNBULL: I would be very pleased to
4 record for the information of the Commission the manner
5 in which this is recorded, and on that basis I would ask
6 that the manner in which I reply to this be taken as being
7 tempered, if necessary, by the way in which it is actually
8 written. However, memory serving me not too well, it would
9 be on this basis: That in view of the obvious increase
10 in expenses that were being borne by the retail pharmacists
11 in obtaining -- particularly related to the salaries being
12 paid to the licensed pharmacists whom they employed -- it
13 was becoming increasingly evident that better trading
14 discounts to the level of 50% would be required from the
15 manufacturers.

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BB/MR/hm

1 MR. MacLEOD: The discussion was that the
2 50% fee was necessary in order to carry on business?

3 MR. TURNBULL: It was becoming increasingly
4 evident that a discount, a trade discount of 50% from list
5 was becoming increasingly necessary.

6 MR. MacLEOD: Was the view of the Association
7 in respect to this matter made known to the manufacturers?

8 MR. TURNBULL: No.

9 MR. MacLEOD: So that there was no action
10 taken subsequent to the discussion?

11 MR. TURNBULL: Not that I recall sir.

12 MR. MacLEOD: Certainly none by the
13 Association?

14 MR. TURNBULL: Not that I recall.

15 MR. MacLEOD: On the pages around 35 and
16 36, and so on, you make some reference to -- beginning
17 on page 34, promotion and advertising and on page 64 you
18 make reference to the policies or practices of certain
19 firms. "There have been instances where a firm has
20 expressed its wish that one or more of its products be
21 withheld from other than prescription sales because ..." and so on and so on. "Physicians often are reluctant to
22 prescribe products which have become counter items or (3)
23 the company has no desire to gain the reputation for being
24 anything but a producer of prescription drugs." I want
25 to ask you could you express any opinion whether there is
26 a tradition or practice in the industry that companies
27 should not, the same companies should not promote to the
28 doctors and to the pharmacists, on the one hand, and on
29 the other hand aggressively promote to the general public?



1 MR. TURNBULL: May I have the first part?

2 You made reference to tradition and something else.

3 MR. MacLEOD: Well is there any such tradition
4 as that? Perhaps I can put the question in focus by
5 reading an item which appeared in Business Week December
6 17th, 1960, which deals with Mead Johnson and Metrecal.
7 "Mead Johnson & Co. Evansville (Ind) maker of nutritional
8 and pharmaceutical products, this week announced a re-
9 organization stemming largely from the success of its
10 Metrecal for weight control. Three separate operating
11 divisions are set up." and these are set out. And the
12 item continues: "In effect Mead Johnson wants to mass
13 market products such as Metrecal without compromising the
14 company's close ties with the medical profession."

15 I referred in examining another witness to the case of
16 Smith, Kline and French apparently starting a separate
17 division to advertise aggressively to the public a cold
18 remedy. Are these instances reflections of a tradition
19 in the industry?

20 MR. TURNBULL: I think it reflects the
21 internal policies of the company concerned, does it not
22 sir?

23 MR. MacLEOD: Well, that is what I mean.
24 I have given you two specific examples and I would ask you
25 if you could express any opinion whether this is a tradition
26 or a practice that is normally followed in the industry.

27 MR. TURNBULL: I think we could say that
28 there is evidence that such is followed, to a degree, in
29 the industry, but whether it is a common practice arising
30 from tradition or otherwise, I don't think I am prepared



1 to state an opinion.

2 I know of instances where a company is
3 involved in many lines of products. I can think of one
4 with cosmetics, patent medicines and pharmaceuticals all
5 tied up within the one company, under the one roof.

6 MR. MacLEOD: Yes, but nevertheless returning
7 again to page 64 you apparently do say that physicians
8 often are reluctant to prescribe products which have become
9 counter items?

10 MR. TURNBULL: That is correct.

11 MR. MacLEOD: Is the physician more likely
12 to prescribe the item if it is detailed to physicians and
13 to pharmacies only, rather than if it is advertised to the
14 general public?

15 MR. TURNBULL: I think we could say that,
16 yes.

17 THE CHAIRMAN: Mr. Turnbull, do you know
18 why physicians are reluctant to prescribe products which
19 have become counter items?

20 MR. TURNBULL: I can only express an opinion
21 sir.

22 THE CHAIRMAN: They do not become any less
23 useful?

24 MR. TURNBULL: I can only express an opinion
25 on it.

26 THE CHAIRMAN: I wondered if you were in a
27 position to express an informed opinion?

28 MR. TURNBULL: It would be my opinion, and
29 I think that physicians will bear this out, that where they
30 are seeking to give the best possible medication to the



1 patient, in keeping with their diagnosis, it is not their
2 desire to make known to the patient that the patient could
3 have just gone and received, or purchased for himself
4 something over the counter.

5 Further, that it is not the patient's or
6 at least not the physician's desire to place himself in
7 the unfortunate position of relating his prescriptions,
8 the items taken off the shelves side by side with items
9 advertised quite blatantly in the radio and T.V. and
10 newspapers.

11 Much of this resolves itself to the patient
12 confidence. This is not being critical of the physician
13 in any way or other. This is all part and parcel of the
14 therapy based on patient confidence both in the physician
15 and the medication that he receives.

16 THE CHAIRMAN: If it is the physician's
17 opinion this over-the-counter drug is the best one for the
18 particular purpose he has in mind for the patient would
19 he not order it?

20 MR. TURNBULL: You mean just suggest to the
21 patient that he get it?

22 THE CHAIRMAN: Or prescribe it, one or the
23 other?

24 MR. TURNBULL: Yes, that does happen,
25 certainly.

26 THE CHAIRMAN: I know it does. I am just
27 wondering why he would be reluctant to do it. The doctor's
28 primary interest is the welfare of his patient, the health
29 of the patient.

30 MR. TURNBULL: There are other products



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1 available to him though.

2 THE CHAIRMAN: May be, but suppose in his
3 opinion this is the best one for a particular patient.

4 MR. TURNBULL: I would presume he would
5 prescribe it, yes.

6 THE CHAIRMAN: You think his objection is,
7 apparently, I suppose that the physician might feel his
8 patient would not be pleased to have had to pay the doctor's
9 fee, plus a prescription fee for something he could have
10 got on his own over the counter?

11 MR. TURNBULL: That may have some bearing.
12 I am thinking of the patient confidence basis in the
13 prescribing of a product that is readily recognizable to
14 the patient, and as a matter of fact the patient himself
15 may not have any confidence in it, from past experience.

16 THE CHAIRMAN: The patient might not have
17 such confidence in his physician generally if he discovers
18 this had happened.

19 MR. TURNBULL: That could be a point, yes.

20 MR. MACLEOD: Would you look at page 39,
21 towards the bottom of the page you have reference to
22 nondescript and fly-by-night companies. What do you mean
23 by non descript companies?

24 MR. TURNBULL: As the sentence says, companies
25 of unknown ability and integrity. That is pretty well,
26 shall we say, unknown or yet to be established or of doubt-
27 ful ability and integrity.

28 MR. MACLEOD: What do you mean by "fly-by-
29 night companies"?

30 MR. TURNBULL: Well I am afraid that the two



1 tie in, although not necessarily. The terminology used
2 here, for want of better terminology possibly, or want
3 of knowledge of better terminology that those who would
4 represent themselves as being part of companies and are
5 found to disappear within a few months. They are here
6 today and gone tomorrow.

7 Those are not unknown things, although I
8 do not wish to attempt to bring any examples, concrete
9 names or examples, concrete names or examples before the
10 group.

11 MR. MacLEOD: The two might necessarily
12 connect. Fly-by-night appears to carry the connotation
13 that it is a very temporary operation.

14 MR. TURNBULL: We could put in here and/or
15 nondescript, and/or fly-by-night companies Mr. MacLeod,
16 yes.

17 MR. MacLEOD: So that your objection then
18 is to a temporary company and to a company whose ability
19 and integrity is unknown?

20 MR. TURNBULL: Provided you take -- I
21 wouldn't want you to read into that sentence the word "and"
22 temporary, and companies of unknown -- and/or, yes.

23 MR. MacLEOD: The nondescript company
24 capitalizes on the sale of only established, well-known
25 drug preparations by often duplicating the exact nature,
26 and so on and so on with prestige items. Now do you regard
27 duplication of an item as wrong providing it does not
28 break any patent law or trade mark law?

29 MR. TURNBULL: Higher in the page: "The
30 multiplicity of similar drug preparations cannot be considered



1 as wholly undesirable provided that the ethics of the
2 companies involved in their production are without question
3 and that the medical and pharmaceutical professions are
4 aware of the merits of the preparations and of the companies."
5 I think that that expresses our opinions on that subject,
6 Mr. MacLeod. We realize that there are many instances of
7 duplication of drug formulations on the market. We realize
8 too that there are possibly many reasons for one company
9 duplicating the formulation of another, as far as the
10 active ingredients go.

11 MR. MACLEOD: Yes. I am not suggesting that
12 your views are wrong. You understand me. I just want to
13 get it quite clear as to the objection that you have to
14 the duplication of the products.

15 MR. TURNBULL: Well it is a many-fold thing.
16 We have stated our opinion on it in that sentence which I
17 quoted.

18 However, you must consider that duplication
19 and multiplicity of similar drug preparations cause a tre-
20 mendous weight upon the inventory of the practising
21 pharmacists. It causes him to possibly have to invest
22 greater sums in stock and undertake advanced methods of
23 stock control both related to the products quantitatively
24 as well as storage-wise, dating and all those matters.

25 It also necessitates the extension of his
26 knowledge of all the products within his keeping and also
27 those that he does not normally have to keep in stock to
28 satisfy the physician in his immediate area. It has its
29 pros and its cons, yes.

30 MR. MACLEOD: All of those considerations



1 are undoubtedly valid Mr. Turnbull but they would apply
2 equally, regardless of the company that duplicated the
3 product.

4 MR. TURNBULL: How do you mean sir?

5 MR. MacLEOD: Well the factors that you
6 have just enumerated are a direct result of duplication,
7 that is, more stock, and so on?

8 MR. TURNBULL: Some of them are.

9 MR. MacLEOD: Those would apply to any
10 duplication regardless of who the duplicator was?

11 MR. TURNBULL: Yes, oh yes.

12 MR. MacLEOD: From that point of view it
13 would be just as objectionable for that to be done by a
14 big company as a small company?

15 MR. TURNBULL: You said from that point
16 of view?

17 MR. MacLEOD: From that point of view, yes
18 and so I am trying to get down to your objection to the
19 duplication of these nondescript, fly-by-night companies.
20 Just what is your objection to this?

21 MR. TURNBULL: As the sentence reads sir:
22 "Regrettably, stemming from duplication are the products
23 of what we may choose to call nondescript, fly-by-night
24 companies of unknown ability and integrity which trade on
25 the prestige enjoyed by others."

26 In other words, it has to be considered that
27 there are a number of companies coming within the categories
28 that I have suggested that choose to say well "me too".
29



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1 MR. TURNBULL: These are formulations.

2 They are accepted - I will get into the act as well. This
3 complicates the whole picture of duplications and multi-
4 plicity of similar preparations and further complicates
5 the factors you and I remarked on here a few seconds ago.

6 MR. MACLEOD: Is it the quality of the
7 products you object to?

8 MR. TURNBULL: It could be, if they are
9 unknown, they are produced by companies of unknown ability
10 and integrity. That is one factor, yes. The quality,
11 of course, enters into every product whether it is dupli-
12 cated by the so-called leader in the field or a little
13 man across the street. Quality enters into every one of
14 them.

15 MR. MACLEOD: I wonder what objection there
16 is apart from quality.

17 MR. TURNBULL: This is only one factor we
18 are discussing at the moment, but quality is the main
19 factor, yes.

20 MR. MACLEOD: If a second company makes as
21 good a product as the first company, does it matter whether
22 the first company is known or not?

23 MR. TURNBULL: I am reaching for straws,
24 Mr. MacLeod. I am not sure what you want me to say or
25 not to say. If you could clarify it to my mind I could
26 possibly do so.

27 MR. MACLEOD: Let me try it then. It is
28 mentioned in the statement in reviewing the criticisms of
29 non-brand name products, generic name products.

30 MR. TURNBULL: Yes sir.



1 MR. MACLEOD: That there seems to be a
2 multiplicity of factors all thrown together, it appeared
3 to the Director and it is difficult to find out the real
4 grounds for objection. They are called foreign, non-brand,
5 called cheap another time - they are called cut-rate,
6 pirated and so on and the only real objection that seems
7 to have any acceptance is where the drug is of poor quality.
8 That is what I am trying to get at, just exactly what your
9 objection is to the drugs of companies other than the
10 recognized brand name manufacturers.

11 MR. TURNBULL: Oh, all right. First of all,
12 sir, the adjectives and what-not, nouns and what have you
13 that you used, foreign, non-brand, cut-rate, and imported
14 I presume that those are used in the Green Book, you make
15 reference to their use in the Green Book. I don't know.
16 I don't recall them used in those particular headings.
17 We haven't used them, the Association hasn't used them;
18 is that correct?

19 MR. MACLEOD: Well, may I give you an example
20 of what I mean. This appeared in the Toronto Daily Star
21 on August 15th, 1961. It reads as follows:

22 "HAMILTON - Cut-rate drug companies are
23 'pirating' costly research done by reputable
24 drug firms, the Canadian Pharmacy Association
25 convention was told here today.

26 H.J. Martel of Montreal, market planning
27 manager for Merck Sharp and Dohme of Canada
28 Ltd., said the mushrooming manufacturers of
29 generic drugs (those sold by formula rather
30 than name) were 'coat-tail riders' on the



1 Canadian drug industry.

2 'Their sole research is to pirate reputable
3 manufacturers' successful products and their
4 marketing consists of beating the drums of
5 their dedication to generic name drugs!".

6 MR. TURNBULL: You are quoting the Toronto
7 Daily Star and not necessarily Mr. Martel, am I right?

8 MR. MACLEOD: Except part of it appears in
9 quotation marks.

10 MR. TURNBULL: Yes.

11 MR. MACLEOD: I took that as an example.

12 The criticism there is apparently of cut-rate drugs and
13 of the pirating of products of established manufacturers.

14 MR. TURNBULL: May we return to your summar-
15 ation and your question a few moments ago. Quality is a
16 vital concern to the pharmacy practitioner, the quality of
17 his products for which he expects to receive a demand in
18 the form of prescriptions written by physicians. Duplica-
19 tions of products are of concern to the pharmacy practitio-
20 ner in that it places a tremendous burden upon his inven-
21 tory both dollar-wise and control-wise. Duplication is
22 something that the practising pharmacist has learned to
23 accept, shall we say, but is something that he will never
24 cease to resist if he possibly can, but he will accept it
25 provided he has an awareness that the products, the dupli-
26 cated products on his shelves are going to be ordered and
27 will meet the demand he expects to receive from physicians.
28 Beyond that the pharmacist is not particularly concerned
29 with product duplication. He is not interested presumably
30 in stocking every product such as might appear in the



1 7,776. He is only concerned with stocking those products
2 for which he will receive a demand. Duplication beyond
3 that presents no problems.

4 MR. MACLEOD: I am still not clear why you
5 singled out duplication by your so-called nondescript and
6 fly-by-night companies as being particularly objectionable.
7 We agree that there are certain objections to duplications
8 that you have stated very precisely.

9 MR. TURNBULL: Have I singled them out as
10 being particularly objectionable?

11 MR. MACLEOD: I rather got that impression
12 from your brief. All I want to do is get clear what you
13 mean.

14 MR. TURNBULL: I don't believe that I have
15 singled them out as being particularly objectionable.
16 No, I don't think so.

17 MR. MACLEOD: If their products are of
18 equal quality with brand name products you have no objec-
19 tion to them?

20 MR. TURNBULL: I don't think we could have,
21 provided there is going to be a usage for them as ordered
22 by the physician.

23 MR. MACLEOD: That is fine. That is exactly
24 what I wanted to get here. Page 40, you say there is no
25 counterfeiting that you know of.

26 MR. TURNBULL: I said not to any great
27 extent do we know it is going on in Canada, or I put it,
28 has any effect in Canada, I believe I said.

29 MR. MACLEOD: I didn't have time to check
30 this, but from my recollection I believe there was some



1 reference made to this matter before the Ontario Select
2 Committee?

3 MR. TURNBULL: That is correct.

4 MR. MACLEOD: Well, of course we can look
5 at that later. In connection with the reputation enjoyed
6 by certain firms do you as a pharmacist, members of the
7 Association of Pharmacists, would it make any difference
8 if a particular dosage form was prepared in the United
9 States and brought into Canada? There is evidence, I
10 think, that Lilly and Upjohn in the past, at least, have
11 manufactured a great many of their products in the States
12 and brought them into Canada ready for sale. Would you,
13 as a pharmacist, accept the products of these companies
14 manufactured in the United States as readily as products
15 manufactured in Canada?

16 MR. TURNBULL: Are you referring, sir, to
17 our statement relevant to the desirability, in our humble
18 opinion, of seeing the Canadian pharmaceutical industry
19 enhanced and grow?

20 MR. MACLEOD: No, I am concerned with the
21 very narrow point of the quality of the products. You
22 have explained at some length in your brief and in your
23 statement the trust the pharmacist puts in certain names.
24 I am wondering about the situation where the product is
25 manufactured in the United States by a company of very
26 high repute in the industry.

27 MR. TURNBULL: Yes. You might realize I
28 am searching the Green Book to find the quotation which it
29 carries, reportedly published in the Globe and Mail as
30 being the words of Dr. Morrell who is the Director of our



1 Food and Drug Directorate. It might simplify my answer
2 to say we wholeheartedly subscribe to Dr. Morrell's
3 opinion.

4 MR. MACLEOD: My point is a very narrow one,
5 it is simply whether you would - let us take a Lilly
6 product, a Lilly product manufactured in the United States
7 as being as good as one manufactured in Canada?

8 MR. TURNBULL: Whether I would?

9 MR. MACLEOD: Yes,

10 MR. TURNBULL: Yes.

11 MR. MACLEOD: Would the same hold true - I
12 have given one American company - in England, the Burroughs
13 Wellcome; Glaxo-Allenburys, the British Drug House, any of
14 the established firms, would you regard products sold by
15 those companies in Canada but manufactured in England as
16 being the equivalent of products manufactured in Canada?

17 MR. TURNBULL: You are seeking a generalized
18 opinion without reference to any specific product. I, of
19 course, must have my opinion recorded in general termino-
20 logy all based around the one word "yes".

21 MR. MACLEOD: Would you assume that the
22 same degree of quality control had been exercised in the
23 case of all products manufactured by such a company in
24 the United States or in England as would be carried out
25 if the product had been manufactured by the same company
26 in Canada?

27 MR. TURNBULL: You mentioned the Eli-Lilly
28 Company in the United States and you mentioned the Bur-
29 roughs Wellcome Company in the United Kingdom - my answer
30 would be yes, sir.



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1 THE CHAIRMAN: Are these opinions that you
2 are giving us now, are these intended to be your own
3 personal opinions or would they be the opinions which your
4 Association would support?

5 MR. TURNBULL: Regrettably, Mr. Chairman, I
6 don't recall the Association as such writing any opinions
7 of this nature. I don't know that the occasion has ever
8 arisen that it has had to discuss these specific instances
9 and relate its opinion from one company to the other.

10 THE CHAIRMAN: It is simply your own perso-
11 nal opinion?

12 MR. TURNBULL: Yes, in my position as Secre-
13 tary-Manager of the Association and as a personal opinion,
14 yes.

15 MR. MACLEOD: Appendix G at the very back
16 of your brief explains the analysis that was made of the
17 Compendium, does it not?

18 MR. TURNBULL: Appendix G is a report rela-
19 tive to generic names in the Compendium of Pharmaceutical
20 Specialties as prepared for me by a faculty member of the
21 University of Toronto. That is correct, sir.

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DD/JW/nm 1 MR. MacLEOD: Do you know if the 7776, total
2 number of products mentioned, is the number of monographs?

3 MR. TURNBULL: I must assume that from the
4 information made known to me, yes.

5 MR. MacLEOD: Will you look at page 4 of
6 Appendix G, "Points to be noticed (1)".

7 MR. TURNBULL: Yes.

8 MR. MacLEOD: And take "sulfathiazole, 34
9 products".

10 MR. TURNBULL: Yes.

11 MR. MacLEOD: Perhaps that is not a good
12 one. Now, do you have the Compendium before you?

13 MR. TURNBULL: Yes.

14 MR. MacLEOD: Will you look a penicillin
15 tablet form on page 344?

16 MR. TURNBULL: Yes.

17 MR. MacLEOD: Do you know how that would
18 be counted?

19 MR. TURNBULL: I presume they would be
20 counted as one.

21 MR. MacLEOD: Although there would be
22 numerous manufacturers of these particular tablets?

23 MR. TURNBULL: Yes, it states "various
24 manufacturers".

25 MR. MacLEOD: That is what I was concerned
26 about. There are a number of descriptions which relate
27 to the product of a particular manufacturer. There are
28 a number of other descriptions which list the various
29 manufacturers, and I was wondering what procedure had been
30 followed in counting them. It would be considerably



1 different?

2 MR. TURNBUIL: Yes, we could reduce the
3 7776. I think you will find that occasionally in here,
4 Mr. MacLeod, where there are a large number of products on
5 the market of a similar nature. The editor saw fit to
6 inject the monograph dealing generally with such products,
7 and then proceeded to deal with as many products as was
8 practical with the information available to him.

9 MR. MacLEOD: Presumably by a closer study
10 of Appendix G that question may be solved.

11 MR. TURNBULL: I doubt whether it would
12 make that much difference from the figure of 7776, and of
13 course you realize we don't claim that this book contains
14 all the pharmaceutical specialties that appear on the
15 Canadian market. Such would be almost impossible. Many
16 were picked up further in the first supplement, and my
17 editors tell me that the second supplement that is awfully
18 close to the end of the press run right now, is a further
19 200 pages, but it includes the veterinary pharmaceutical
20 products section, which would take up the majority of those
21 200 pages.

22 MR. MacLEOD: I just point out in passing
23 on page 49 that your brief appears to quote the Director
24 slightly out of context.

25 MR. TURNBULL: I am sorry I didn't hear
26 the last part.

27 MR. MacLEOD: Your brief appears to quote
28 the Director's Green Book slightly out of context. That
29 is "consumer subsidy of institutional prices".

30 MR. TURNBULL: My apologies if I have.



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1 MR. MacLEOD: I don't think the Director
2 had reference to quite the same situation that you had.
3 You appear to relate his comments to purchases of different
4 trade channels.

5 MR. TURNBULL: Yes, I would not change my
6 interpretation, but I would also apologize if my interpre-
7 tation differs from that as expressed in that particular
8 paragraph.

9 MR. MacLEOD: On page 50 of your brief you
10 express the view at the beginning of the last paragraph,
11 "From the manufacturer's point of view, the formulary
12 system tends to substantially reduce, in hospitals and
13 government institutions, or indeed, eliminate the normal
14 protection afforded his brand name."

15 MR. TURNBULL: Yes, was there something
16 about that?

17 MR. MacLEOD: No, well, I take it that you
18 subscribe to the converse view, that the brand name does
19 affect a measure of protection at the retail level. You
20 say it does not, it is different, the hospital situation
21 is different from the retail level because of this feature.

22 MR. TURNBULL: Yes, I would not change that
23 sentence, Mr. MacLeod.

24 MR. MacLEOD: I am just pointing out that
25 it appears, if that is true, to necessarily follow that
26 the use of the brand name at the retail level does have a
27 dampening effect upon competition.

28 MR. TURNBULL: No sir, that is not implied.

29 MR. MacLEOD: If the elimination of the
30 brand name permits price competition, surely the retention



1 of the brand name must tend to eliminate it. If the
2 latter part is not true, then I suggest that your suggestion
3 does not carry any weight.

4 MR. TURNBULL: No, I am sorry sir, but we
5 are not discussing dollars and cents and competition here.
6 Our reference is to the normal protection afforded a brand
7 name.

8 MR. MacLEOD: And because the normal pro-
9 tection afforded by a brand name is taken away, the
10 manufacturer is forced into an extreme competitive field
11 pricewise. When you take it away, you force him into
12 extreme competition pricewise. Surely, if you leave it
13 there, then you don't subject him to the same competition.
14 Surely that follows from your statement?

15 MR. TURNBULL: I don't agree, sir, that the
16 leaving of the brand name necessarily eliminates competition,
17 but the elimination of the brand name in purchasing under
18 the tender system does definitely eliminate the normal
19 protection afforded to a brand name, and at the same time
20 the tender system does -- and I think this is an acknowledged
21 thing -- force the manufacturer into an extreme competitive
22 field, pricewise if he wishes to benefit by a coincident
23 prestige and promotional value et cetera, as such
24 might pertain his particular brand.
25 The word "extreme" is not incorrectly used there because
26 the manufacturer is from day to day involved in the com-
27 petitive field and under the tender system, the competition
28 becomes much more extreme, much more aggressive, you might
29 say, to get one mass contract, and I say one mass contract
30 or one agency, one individual agency, or what have you.



1 I don't think that we are inferring that.

2 MR. MacLEOD: I thought you were inferring
3 that the elimination of the effectiveness of the brand
4 name had some effect on competition at the hospital level.

5 MR. TURNBULL: Yes.

6 MR. MacLEOD:: If that is what you are saying,
7 I think the logical consequence can be deduced, and I
8 don't want to waste time on it.

9 MR. TURNBULL: I don't agree though with
10 the converse as you stated is correct, and if we may both
11 record our opinions, sir ---

12 MR. MacLEOD: Yes, surely. It is a matter
13 of argument, perhaps. As long as we have your position
14 clear, that is all that is necessary.

15 On page 56 there is some reference to the
16 size of pharmacies and the fact that retail pharmacy is
17 not big business. Would you say that the principal reason
18 for that is the legislation relating to the operation of
19 pharmacies?

20 MR. TURNBULL: Which legislation do you mean,
21 sir?

22 MR. MacLEOD: Well, that in certain provinces
23 at least the owner must be a registered pharmacist, that
24 is if it is a company, the majority of the shareholders
25 must be registered pharmacists, and legislation along
26 those lines?

27 MR. TURNBULL: I suppose it could have
28 this effect. On the other hand, I think that possibly a
29 greater reason is the desirability of having pharmaceutical
30 services available in every community in Canada, regardless



1 of its size, and also the desire of the professionally
2 trained individual to establish himself in his own practice.
3 I think those factors are of considerable importance.

4 MR. MacLEOD: On page 57 in the last
5 paragraph and the third sentence, "We reiterate here that
6 actions on the part of individual pharmacists incompatible
7 with this principle can lead only in the direction of a
8 general lowering of standards."

9 To what does "principle" refer there, is it
10 orderly marketing?

11 MR. TURNBULL: Yes.

12 MR. MacLEOD: What do you mean by the term
13 "orderly marketing"?

14 MR. COOK: Of course the definition is
15 contained in the sentence in which it is used, "By the
16 1960 amendments to Combines legislation".

17 MR. TURNBULL: Do we have Bill C 58 with us
18 in our files? Also I believe that the Minister of Justice
19 in introducing bill C58 to the House in 1960 defined it
20 in an excellent manner.

21 MR. MacLEOD: I want to be sure your
22 "principle" refers to "orderly marketing" and "orderly
23 marketing" refers to the amendments to the Combines Act.

24 MR. TURNBULL: Those particular clauses,
25 yes sir.

26 MR. MacLEOD: In what way do you envisage
27 a general lowering of standards resulting?

28 -

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1 MR. TURNBULL: Well, it is a very difficult
2 thing to answer when a person does not have a pen in his
3 hand possibly, but there are many things that affect this
4 whole picture, many of them directly related to the service
5 considerations of practising pharmacy, and the service
6 considerations directly related to the retail pharmacy or
7 drugstore, whichever you may wish to call it, and it would
8 be difficult to summarize them.

9 However, I think the best way to present an
10 answer to you, Mr. MacLeod, would be to attempt to draw a
11 picture as I and some of my colleagues see it, that if
12 retail pharmacists mainly from the business part of their
13 operations are forced in by the extreme competitive prac-
14 tices all based on pricing and price cutting - my reference
15 here is to front shop merchandise of course - if they are
16 forced into that type of thing whereby prices are substan-
17 tially reduced - and I am not talking about sales and inci-
18 dental reductions here for after all that is in the field
19 of competition - but if these other factors come into play
20 causing a substantial reduction in prices and a consequent
21 substantial reduction of income to the individual retail
22 pharmacist, he is of course going to be forced to find
23 other sources of revenue so that he can keep his doors
24 open and three meals a day on the table.

25 Now, if the pharmacist is forced into these
26 extreme competitive circumstances price-wise, can we not
27 consider that eventually one or another pharmacist or more
28 are going to carry such practices into their prescription
29 department?

30 Now, that is fine as long as a few are doing



1 that. Possibly they can afford to do it, but the other
2 pharmacists about them are then forced to enter into that
3 competitive field, and you will have, shall we say, pres-
4 cription prices being offered at any kind of a price
5 without due consideration to the ethics involved in
6 rendering pharmaceutical service, and corners are going to
7 be cut some place so that the man can keep his doors open.
8 If he is cutting corners on both quality and moral obliga-
9 tion, this is going to have an extremely bad effect on the
10 general public which relies on the pharmacist to convey
11 efficient and nothing but efficient pharmaceutical services
12 to them.

13 That is a very long dissertation, but
14 generally that is the way ---

15 MR. MACLEOD: In the sense that you have
16 just explained, is your Association against price cutting
17 at the retail level, in the pharmacy?

18 MR. TURNBULL: No, I did not say that. No,
19 I was describing what the individual pharmacist's position
20 may be in this whole thing, and I am also describing why
21 our Association, from time to time, has joined with other
22 associations in presenting ourselves before the Federal
23 Government, including the Prime Minister, to bring to his
24 attention the danger of these practices.

25 MR. MACLEOD: Well, is it your position that
26 widespread price cutting at the retail pharmacy level may
27 lead to lowering of standards? Is that not what you have
28 just said a few moments ago?

29 MR. TURNBULL: I said that in part, yes. I
30 said if all these various influences work to bring pressure



1 upon the retail pharmacist, there will be, in our humble
2 estimation, principles established which could only lead
3 in the general direction of a lowering of standards of
4 pharmaceutical practice.

5 MR. MACLEOD: Now, I had better get along
6 with this a little faster. There is considerable discus-
7 sion in your brief about the role which the retail pharma-
8 cist plays as advising doctors on drugs.

9 MR. TURNBULL: Yes, sir.

10 MR. MACLEOD: I wonder if we could relate
11 that to figures which were given by earlier witnesses;
12 about 38% of the detailman's time being spent away from
13 doctors.

14 MR. TURNBULL: I did not catch that, Mr.
15 MacLeod.

16 MR. MACLEOD: There were figures given earlier
17 which suggested that 38% or some such figure of the detail-
18 man's time was not spent detailing doctors; it was spent
19 on other duties. Could we fairly consider that a good
20 deal of the time that he spends with retail pharmacists
21 is really for the doctor's benefit, the information that
22 he gives retail pharmacists is often made known to doctors
23 and used by doctors?

24 MR. TURNBULL: Yes, I believe so.

25 MR. MACLEOD: On the table on page 62,
26 average cost of ingredients, is that list price or actual
27 cost price to the druggists?

28 MR. TURNBULL: It is my understanding that
29 this was actual cost based on the average of actual cost
30 of ingredients.



1 MR. MACLEOD: And on page 64 you had some
2 discussion with the Chairman about percentages given there,
3 at least 50% headache remedy market. Does that mean at
4 least 50% referred to particular brands of headache reme-
5 dies?

6 MR. TURNBULL: No, sir.

7 MR. MACLEOD: What does it mean?

8 MR. TURNBULL: You are thinking of the last
9 line, or are you directing attention to the last line,
10 "At least 56% - headache remedy market"? No, I do not
11 think that it can conceivably relate to one product only.

12 MR. MACLEOD: I am just trying to clear up
13 names.

14 MR. TURNBULL: One class of product, yes.

15 MR. MACLEOD: 56% of the total purchasers
16 of headache remedies prefer some particular brand?

17 MR. TURNBULL: No, no. That is not what it
18 says. If we can get your sentence again. At least 56%,
19 according to this particular consumers' survey, indicated
20 a preference for a headache remedy other than those which
21 are commonly advertised to the consumer.

22 THE CHAIRMAN: I thought it was the reverse.
23 I thought it meant 56% preferred a headache remedy which
24 they could just obtain by asking for it over the counter,
25 as distinct from prescriptions or something of that kind.

26 MR. TURNBULL: That is correct, sir, but
27 the o-t-c pharmaceuticals that are referred to here are
28 those drugs which are not legislatively restricted to
29 prescription only sale, but at the same time are not
30 marketed under the Patent or Proprietary Medicines Act,



1 and therefore must be restricted to drugstore sale only
2 because they are governed by the Food and Drugs Act.

3 These are the products that we call pharmaceuticals.
4 Now, they may be used for prescriptions only
5 or they may be upon demand obtained over the counter.

6 Let me use as an example in this particular
7 category if I may name names, Frosst's analgesic preparation,
8 Frosst's 222, which is a headache preparation and
9 is not registered under the Patent or Proprietary Medicines
10 Act, nor could it be, and yet it is not restricted to the
11 prescription-only sale.

12 It may be sold upon demand of the customer,
13 but it is not restricted - it contains one-eighth of a
14 grain of codeine, amongst other ingredients, and is
15 restricted to retail or to pharmacy sale only.

16 THE CHAIRMAN: How about Frosst's 217's?

17 MR. TURNBULL: The same thing.

18 THE CHAIRMAN: That does not contain codeine?

19 MR. TURNBULL: I stand corrected, but I do
20 not believe it is registered under the Patent or Proprietary
21 Medicines Act. This, of course, could actually go
22 into other products.

23 THE CHAIRMAN: This phrase "at least 56% -
24 headache remedy market", are people who will ask for
25 things like Frosst's 222's?

26 MR. TURNBULL: Or 217's, or you can carry
27 this into other fields.

28 THE CHAIRMAN: As distinct from a patented
29 cough syrup?

30 MR. TURNBULL: No, keeping in that same



1 category as distinct from, and we are naming names again,
2 Bayer's Aspirin or Bufferin or Anacin and that type of
3 thing that is sold in other than retail pharmacies.

4 THE CHAIRMAN: The whole market you are
5 speaking about is an over-the-counter market?

6 MR. TURNBULL: This is the consumer market,
7 yes.

8 THE CHAIRMAN: You are not referring at all
9 to a third kind of market, the prescription market?

10 MR. TURNBULL: No, no. This is strictly a
11 consumer survey that was conducted by the Newspaper Publi-
12 shers' Association, and I presume - I have seen these,
13 we have this particular one in the office of course, and
14 I have seen them. I think they are published every two
15 years, and they have various degrees of significance to
16 the newspaper publishers that they relate to the level of
17 advertising that is being done in each of these fields.
18 They break this right down into products.

19 THE CHAIRMAN: Now, the cough syrup, where
20 your figures are 21%.

21 MR. TURNBULL: Yes.

22 THE CHAIRMAN: Does that mean 21% of the
23 people who want a cough syrup are not getting it by way of
24 prescriptions; will ask for an o-t-c pharmaceutical which
25 they can only get through a drugstore or pharmacy?

26 MR. TURNBULL: Yes.

27 THE CHAIRMAN: And the other 79% may take
28 something that is advertised?

29 MR. TURNBULL: Yes.

30 THE CHAIRMAN: They may buy at the pharmacy



1 store or they may buy somewhere else?

2 MR. TURNBULL: Yes.

3 MR. FRAWLEY: What is the significance of
4 saying the sale of Frosst's 222's is limited to the retail
5 pharmacies rather than Loblaw's counters, for instance?

6 MR. TURNBULL: Well, if we may speak of
7 222's, 222's contain, amongst other things, one-eighth of
8 a grain of codeine, and as such, any preparation containing
9 any narcotic is controlled by the Narcotic Control Act of
10 Canada.

11 The Narcotic Control Act permits prepara-
12 tions containing one-eighth of a grain per dose or one-
13 third of a grain per fluid ounce to be sold without a
14 doctor's prescription.

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FF/MR/hm

1 MR. TURNBULL: They cannot be registered
2 under the Patent or Proprietary Medicines Act, and this
3 then turns back to Provincial Legislation. The Pharmacy
4 Act has schedules of drugs which may, for some particular
5 reason or other, be sold only through the hands of a
6 pharmacy practitioner and certain exceptions. In the
7 majority, if not all provincial Pharmacy Acts those products
8 registered under the Patent or Proprietary Medicines Act
9 of Canada are exempt from that particular provision.

10 MR. FRAWLEY: I understand Mr. Turnbull
11 why it is limited. I am wondering why you say there is
12 a control because everybody and his brother can go in and
13 buy 222's in any drug store and the person selling to him
14 will be just one of the girls selling cosmetics, and so
15 on. At least is that so? Because if that is so I see
16 no protection. What is the point of limiting it to the
17 retail pharmacies?

18 MR. TURNBULL: We do not deem this as being
19 a desirable thing Mr. Frawley. As a matter of fact
20 organized pharmacy has placed itself on record as desiring
21 that something be done about this by writing letters and
22 urging its membership not to allow such a thing to take
23 place and at the same time we have approached -- and this
24 has gone on for some two or three years now -- we have
25 approached the authorities in Ottawa to support us in this
26 work morally, in the first place, by backing up our
27 desires not to see such marketing practices followed by
28 those who do not wish to be led, shall we say, by the
29 Associations or placing some legal restriction on the
30 sale.



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Turnbull

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1 I can speak most frankly and personally,
2 at the particular time we were discussing pricing and
3 cutting prices and whatnot, and the significance to them
4 in the retail pharmacy and what could happen and it is only
5 a few weeks ago that the Toronto papers -- advertisements
6 in the Toronto papers carried what were considered to be
7 by the advertisers a tremendous price reduction on Frosst
8 222 and I think this is a shameful situation that the public
9 of Canada would allow itself to be led into purchasing
10 more and more codeine preparations just because somebody
11 wants to use a popular item to attract business.

12 MR. FRAWLEY: But Mr. Turnbull, I suppose
13 it can only go in one direction as far as you are concerned?
14 You would make it a prescription drug. That's the only
15 place it can go.

16 MR. TURNBULL: I would hope that it would
17 not have to go like that. I was looking for a piece of
18 correspondence. There was a great move in Ontario and
19 certain other Provinces just two or three years ago where
20 the Associations requested their members to place 222's,
21 and similar products, in a position in the retail pharmacy
22 where they would not be readily accessible to just picking
23 them up in spot purchasing and, in any event, if the clerk
24 on the counter was making the sale she drew the sale to
25 the attention of the pharmacist practising in that
26 establishment before completion of the sale.

27 We feel that such a procedure is a most
28 worthy procedure.

29 MR. FRAWLEY: I just wanted some information
30 but I am afraid that I should have taken the advice you



1 gave me but quite frankly I had no idea it would lead into
2 that. I hoped 222's were not going to start to become
3 more costly to get. By the time you consult your physician,
4 pay the physician \$10.00, go into the drug store, pay a
5 prescription fee, that would be a costly thing.

6 THE CHAIRMAN: Not unless some change takes
7 place.

8 MR. TURNBULL: If the merchandisers start
9 kicking it around a lot undoubtedly you will. Certainly
10 hope that such a situation would not be -- pushing codeine
11 down the throats of Canadians to that point.

12 THE CHAIRMAN: Mr. Turnbull we have your
13 objections to Frosst 222 being sold indiscriminately on
14 the ground that they contain codeine. I wondered about
15 Frosst 217. You say they are not registered. They do
16 not contain codeine. I take it you have not the same
17 objection to that?

18 MR. TURNBULL: Well they are a little bit
19 -- there is no potentially addicting ingredients in 217.
20 It is in the A.S.A. combination.

21 THE CHAIRMAN: It could be registered under
22 the Proprietary Medicine Act, could it?

23 MR. TURNBULL: I think so, with those other
24 two products, yes. It could be registered if the Frosst
25 company, the manufacturers of that particular preparation
26 wished to register it, yes, they would be quite a liberty
27 to do so.

28 THE CHAIRMAN: I thought that was the
29 position. Now just to complete the picture: What is the
30 position with regard to the sale of Frosst 292?



1 MR. TURNBULL: Of course Frosst 292 is
2 definitely restricted to sale by prescription only on the
3 individual prescription.

4 THE CHAIRMAN: They contain a greater
5 quantity of codeine?

6 MR. TURNBULL: One-half grain.

7 THE CHAIRMAN: And that is the reason?

8 MR. TURNBULL: Yes sir.

9 THE CHAIRMAN: That is the reason they are
10 restricted to prescription?

11 MR. TURNBULL: Yes sir.

12 MR. FRAWLEY: In the United States without
13 any prescription at all you can buy Upjohn's Cheracol?

14 MR. TURNBULL: Of course there are quite
15 a few things you can buy in the United States. You can
16 still buy Paragoric in some parts of the United States
17 but you cannot buy 222's down there.

18 THE CHAIRMAN: We are dealing with Canada.

19 MR. MacLEOD: Will you turn to page 71
20 of your brief? There was some question that arose the
21 other day as to the price the retail pharmacy would charge
22 for 50 tablets which came in 100 tablet containers. The
23 list price was \$10.50. What would be the price of that
24 under the suggested pricing procedure evolved by your
25 Association?

26 MR. TURNBULL: Be \$6.50 according to my
27 calculations, Mr. MacLeod, and based on that I presume that
28 the original 100 quantity would have been \$11.25. Am I
29 correct?

30 MR. MacLEOD: I don't know. I just knew that



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1 the list -- manufacturers' list price was \$10.50 for 100
2 and the question which arose was how much would a purchaser
3 pay for 50?

4 MR. TURNBULL: In accordance with this
5 schedule now. If this schedule was being applied. I don't
6 know what the purchaser might be charged in any individual
7 location.

8 MR. MacLEOD: I realize that. I just wanted
9 to see what it would come to under your procedure. On
10 page 77 you refer to the possibility of confusing similar
11 names. Are the four examples that you have given trade
12 names?

13 MR. TURNBULL: Yes sir. They are generally
14 considered as trade name or brand name or proprietary name,
15 yes.

16 MR. MacLEOD: Just arising out of a point
17 you mentioned a moment ago, somewhat later in your presenta-
18 tion you compared prescription prices in the United States
19 and in Canada?

20 MR. TURNBULL: Yes.

21 MR. MacLEOD: And you find that prescription
22 prices are higher, on the average, in the United States?

23 MR. TURNBULL: According to surveys con-
24 ducted there and surveys conducted here, yes.

25 MR. MacLEOD: Well, that could possibly be
26 affected, I assume, by the fact that some items are not the
27 same prescription drugs in the two countries, as you
28 mentioned a moment ago.

29 MR. TURNBULL: Mr. MacLeod, we defined a
30 prescription drug. We defined a prescription drug as any



1 drug that is provided on the order of a physician to an
2 individual patient who receives a complete pharmaceutical
3 service connected with that drug, whether it be legislatively
4 designated as a prescription only drug or not. There is a
5 very, very small number of drugs which legislation stipulates
6 may only be provided on an order of a physician, dental
7 practitioner or veterinarian.

8 MR. MacLEOD: Would the removal or placing
9 of tranquilizers, as a class, on the prescription list,
10 that is the legal prescription list, be likely to affect the
11 average cost of prescriptions?

12 MR. TURNBULL: Not in my humble opinion,
13 no. Well, apparently it has not. I mean there has been
14 a gradual progression. There has not been any serious
15 change in any one year has there?

16 MR. MacLEOD: No, not according to the
17 figures you gave.

18 MR. TURNBULL: Those are our survey figures.

19 MR. MacLEOD: It just occurred to me if
20 people are buying tranquilizers over the counter in the
21 United States, and I do not say they are. I don't know
22 and if they have to get a prescription for them in Canada
23 it might make a difference?

24 MR. TURNBULL: It could do.

25 MR. MacLEOD: You don't have any facts?

26 MR. TURNBULL: We do not have any figures.
27 It is not that we do not have any facts on it, a prescrip-
28 tion, an average prescription does not relate itself to
29 any specific drug or drug classification, of course.

30 MR. MacLEOD: Now with reference to page 97



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1 you say: "The source of the Director's suggestion that
2 pharmacists are urged to use a code is not known to this
3 Association."

4 MR. TURNBULL: That is correct sir.

5 MR. MacLEOD: I would undertake to give
6 the Commission the evidence on which that statement is
7 based. I think I know what it is. If I am mistaken, I
8 will ask at a later date that the statement be taken out
9 of the book.

10 MR. TURNBULL: We would be very pleased. We
11 are not questioning this sir. We are merely stating that
12 for the life of us we cannot find any reference to it in
13 anything that is available to us. In fact, we would be
14 extremely interested to know of its source as well, if we
15 might.

16 MR. MacLEOD: You also said, I think, that
17 your Association does not exert any pressure on any group
18 to follow any prescription guide.

19 MR. TURNBULL: That is correct.

20 MR. MacLEOD: Are you able to make that
21 statement in connection with all Provincial Associations
22 which are members of your body?

23 MR. TURNBULL: That is correct.

24 MR. MacLEOD: Do you think any moral pressure
25 has been exerted by them on the individual members?

26 MR. TURNBULL: Well I am not too sure of
27 moral pressure or what might come within your definition
28 of moral pressure but my answer would be no.

29 THE CHAIRMAN: Mr. Turnbull, you said no
30 pressure by any of the provincial bodies, is that an opinion



1 or are you in a position to tell us --

2 MR. TURNBULL: Mr. MacLeod asked me -- I
3 am sorry if I misunderstood the question. I understood
4 him to say whether we had applied any pressure on the
5 Provincial Associations.

6 THE CHAIRMAN: No, no, that is not what he
7 meant.

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THE CHAIRMAN: That isn't what he meant.

2

MR. TURNBULL: I am sorry.

3

MR. MACLEOD: My question was were you in a
4 position to state whether your member associations had,
5 in turn, applied any pressure on their members?

6

MR. TURNBULL: Would you leave out the "in
7 turn". I think we have answered no.

8

MR. MACLEOD: No.

9

MR. TURNBULL: My answer to your question is
10 no, I am not in a position to state.

11

MR. MACLEOD: Just one other point, do you
12 suggest the practices of retailers getting better than
13 regular prices through such things as rebates and so on
14 is more widespread than is indicated by the Director's
15 Statement? Can you put your hand on your section on whole-
16 salers?

17

MR. TURNBULL: I think I could give it to
18 you, yes. It starts at page 54, I believe.

19

MR. MACLEOD: The Director, in his Statement,
20 is mentioning rebates. You consider the practice is much
21 wider?

22

MR. TURNBULL: We were just filling you in
23 on information there, sir, that there are in various parts
24 of Canada other wholesalers either wholly or partly owned
25 by shareholders who are the practising retail pharmacists.

26

MR. MACLEOD: Do you know if that is true of
27 Dale Laboratory Limited, in Montreal?

28

MR. TURNBULL: I am not familiar with their
29 practices.

30

MR. MACLEOD: And Pharmacie...



1 MR. TURNBULL: Pharmacie Moderne?

2 MR. MACLEOD: Moderne.

3 MR. TURNBULL: I believe Pharmacie Moderne
4 is a shareholder. I stand corrected. There is another
5 one, Pharmacie Moderne and - do you have the other ones?

6 MR. MACLEOD: Pharmacie Universal?

7 MR. TURNBULL: It is either one of those.
8 I stand corrected. I should know. I have very good
9 friends there.

10 MR. MACLEOD: National Drug in Winnipeg?

11 MR. TURNBULL: I don't know.

12 MR. MACLEOD: Northwest Drug Company,
13 Edmonton and Calgary?

14 MR. TURNBULL: Oh, definitely, yes.

15 MR. MACLEOD: In any event, without going
16 into details, you suggest that the practice of special
17 rebates is more extensive than one would be led to believe
18 by reading the Director's Statement?

19 MR. TURNBULL: Yes, these are not really
20 rebates. They are shareholding interests based on volume
21 of purchase of certain products during the course of a
22 year. It is a dividend proposition.

23 MR. MACLEOD: I think this will be my final
24 question. Where is your table of different prices paid by
25 retailers?

26 MR. TURNBULL: I think it is about page 103,
27 102 - 103, is it not? Yes, 103.

28 MR. MACLEOD: Do deals play an important
29 part in fixing the prices set out in this table?

30 MR. TURNBULL: They play some part of it,



1 MR. MACLEOD: Is it a case of large opera-
2 tions being able to buy in much larger quantities and get
3 better prices; is that the reason for the procedure in
4 that?

5 MR. TURNBULL: Not in all instances. Deals
6 as well as individual products have entered into the
7 chart here and the figures were determined, as we pointed
8 out this morning -are based on absolute lows and highs,
9 not on average figures, of course, and would, to some
10 extent, depend on the source of purchase and the volume
11 of purchase related to the particular store, yes.

12 MR. MACLEOD: I think those are all the
13 matters I have.

14 MR. COOK: I wonder, Mr. Turnbull, would
15 you clear up one point referring to the deals. Do deals
16 have any application on prices of prescription drugs?

17 MR. TURNBULL: A qualified no, Mr. Cook,
18 because we defined prescription drugs just a few minutes
19 ago - conceivably there are some drugs that might be
20 purchased in accordance with some particular purchasing
21 deal.

22 MR. COOK: Would you consider my question
23 directed to drugs required by law to be furnished only on
24 prescription.

25 MR. TURNBULL: No, I don't think I can
26 think of any case in which such drugs are involved in
27 deals, nor can I think of any instances where there would
28 be any advantage to the manufacturer coming up with a
29 deal.

30 THE CHAIRMAN: It would be o-t-c



1 pharmaceuticals, proprietaries and sundries?

2 MR. TURNBULL: Oh, yes.

3 THE CHAIRMAN: In this field, yes.

4

5 --- Short Recess

6

7 THE CHAIRMAN: Ladies and gentlemen, I
8 advised some time ago we were very hopeful Dr. Best would
9 be able to be with us. He has arrived. Unfortunately
10 because of his busy schedule I understand this is the only
11 time he can be available. We do wish to hear what he has
12 to tell us, particularly about research. Perhaps Mr. Turn-
13 bull would stand down for the time being and we will see
14 what we can do.

15 MR. COOK: There is no objection, but I was
16 under the impression we were through with Mr. Turnbull.

17 THE CHAIRMAN: Mr. MacLeod has completed
18 his questions. I have been under the impression Mr. Frawley
19 may have some questions.

20 MR. COOK: I assumed from the fact Mr. Mac-
21 Leod had proceeded that Mr. Frawley had no questions.

22 THE CHAIRMAN: I think that will be an
23 assumption not justified by facts.

24 MR. TURNBULL: I have great respect for Dr.
25 Best and I am only too pleased to stand down for him.

26

27 DR. C. H. BEST, called

28 THE CHAIRMAN: Make yourself as comfortable
29 as you can. There is a lectern but as you have no papers
30 you really don't need it. I don't know if we have your



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Best

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1 full name.

2 DR. BEST: Charles H.

3 THE CHAIRMAN: I knew it was Charles. Dr.
4 Best, we are particularly interested in hearing something
5 of your experience and views with regard to research of
6 penicillin and other drugs. Perhaps you may be able to
7 help us considerably in that aspect of the whole drug
8 industry. Would you like to make a general statement or
9 would you like to answer questions?

10 DR. BEST: If I may make a short statement
11 and then I would be glad to answer any questions that I
12 can. I spent 21 years as one of the Directors of the
13 Connaught Laboratory of the University and became familiar
14 with the method of preparing and standardizing quite a
15 number of substances and with the research that had to be
16 done continuously in these fields and in new fields where
17 we hoped there would be additional products. The situa-
18 tion in the Connaught Laboratory is quite unlike that in
19 industry because it is a department of the university and
20 a lot of things that apply there would not enter other
21 fields.

22 For many years now I have been Director of
23 the Banting and Best Department of Medical Research and
24 before that the Chair of Physiology in the Medical School.
25 The Department of Physiology was the Department in which
26 insulin was discovered and the Ontario Government later
27 created the Banting and Best Department for research.
28 The two departments are now combined in one building, a
29 large part of them, and we have a staff of 60, 70 research
30 people and a corresponding number of technical assistants,



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Best

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1 and a part is secured from Government grants. I have
2 been in Ottawa for nearly 10 days now working in the new
3 Medical Research Council of Canada and for the Defence
4 Research Department and for the Department of National
5 Health and Welfare. All these bodies make grants to
6 research. Our objective up there was really to co-ordin-
7 ate the giving of grants as far as possible by Government
8 agencies. At the last meeting a lot of other agencies
9 were represented, voluntary agencies in Canada.

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1 I would like to make three points. One,
2 is that some of the drug companies make available money
3 which helps research in a variety of ways. I had here,
4 for four or five days just recently, the Director of the
5 Ciba Foundation in London. The Ciba Company, which has
6 its headquarters in Switzerland and has branches through-
7 out the world, has set up what they call the Ciba Founda-
8 tion. I don't know the extent to which they finance it, but
9 it must be a very large amount each year.

10 Then they leave the spending of this money
11 entirely to a Board which includes Lord Airey, one of my very good
12 friends, and Sir Henry Dale and a great many others, and
13 I am one of the so-called directors from Canada.

14 The objective of this Foundation is the
15 dissemination of medical and chemical knowledge. They
16 have literally scores of meetings throughout the year and
17 then they publish books on these new research findings.

18 The travelling expenses of scientists from
19 all over the world, their living expenses while in London,
20 and the cost of preparing and publishing the books is
21 borne entirely by the Ciba Foundation. They have a branch
22 here in Montreal. The company has a branch here in Mon-
23 treal.

24 This Foundation in London has really become
25 the headquarters for medical research activity in England,
26 and they sometimes hold meetings in other parts of the
27 world, financing the whole procedure.

28 I thought that was an interesting bit of
29 knowledge because I can think of few things that have
30 helped more since the war than these special Foundation



1 meetings where one subject would be discussed, where some
2 of us would have the opportunity of suggesting names from
3 Australia or South Africa or any other country, and these
4 people would come, and we would spend a week trying to
5 see where the frontiers of knowledge were and what research
6 should be done next.

7 THE CHAIRMAN: Dr. Best, is that what you
8 call "pure research"?

9 DR. BEST: It is on the medical side. I
10 would say it is entirely "pure research".

11 THE CHAIRMAN: It is not connected in any
12 direct way at any rate with the production of new drugs
13 by or for Ciba?

14 DR. BEST: No. I have been at many of these
15 meetings. For instance, one meeting which I attended
16 was on the problems of aging, and books have been published
17 on that, prizes given to the best research all over the
18 world, and I think that would be typical of all the other
19 meetings which I have attended, but no drugs came into the
20 deliberations at all.

21 I think there might be meetings where there
22 would be pharmacology, and then the importance of various
23 drugs would be discussed, but certainly never with any
24 bias or with any special interest of the Ciba firm concer-
25 nered. I have never seen that. That could not conceivably
26 happen, I think. It would spoil their whole effort if
27 there was the least bit of that in the procedure, so it is
28 quite detached and completely scientific.

29 Something the same is done in the United
30 States. The Macy Foundation - I do not even know whether



1 the Macy people are interested in drugs or not - but the
2 money that comes from the Macy Foundation goes to make
3 possible these meetings.

4 THE CHAIRMAN: That is the R.H. Macy
5 Company?

6 DR. BEST: Yes. Well, this group that runs
7 the Macy Foundation is this medical group, that does the
8 same thing as the Ciba Foundation in London.

9 When you are trying to build new buildings,
10 you get money from wherever you can, and we have been
11 fortunate recently in getting to complete our building
12 here an amount of about \$190,000 from the Wellcome Trust.
13 That was created by the Wellcome Foundation. The Wellcome
14 Foundation is the name of Burroughs and Wellcome, the old
15 pharmaceutical firm, and that firm was left by Sir Henry
16 Wellcome to a group of trustees, and the profits on the
17 firm are supposed to go to research and investigation.
18 I don't know the details of that except I suppose the
19 businessmen could decide how much had to be put back into
20 the business and how much could be made available for
21 research. But I do know that the Wellcome Trust has done
22 a lot of good all over the world in research, and they
23 have made a number of grants here in Canada, including
24 this one of \$190,000 recently of bricks and mortar to
25 complete our building.

26 Then, the third point is that in the early
27 days of insulin when we were struggling to disseminate
28 knowledge of how to make it, we selected one company in
29 the United States which we thought was the best one at
30 that time to work closely with us in the University of



1 Toronto.

2 That was the Eli-Lilly Company, and they
3 made great contributions, all of which were given to the
4 University of Toronto, which in turn made them available
5 throughout the world, contributions to the methods for
6 making insulin.

7 Years ago when we were just starting our
8 building, donations were given by grateful diabetics
9 throughout the world and by Government agencies and so on.
10 The Eli-Lilly Company at that time gave a quarter of a
11 million dollar gift for bricks and mortar to construct
12 the research building which we now enjoy. I know that a
13 similar thing happened from various sources, and when the
14 Banting Institute was created, gifts were made from drug
15 companies, Governments and individuals, so that the Banting
16 Institute could be created.

17 I should also say I think that although I
18 have not looked at the records carefully to give you a
19 detailed account, we do accept grants providing there are
20 no strings attached to them from a variety of pharmaceuti-
21 cal companies.

22 Everything we do must be published and unless
23 we are interested in pursuing a certain line of research,
24 we would not do it, no matter how much money was made
25 available.

26 Our people are trained along certain lines,
27 and if it suits our purpose to pursue a certain investiga-
28 tion, we would accept grants from pharmaceutical companies.
29 We are now in receipt of grants from five or six of them,
30 I should think.



1 Most of those have to do with these oral
2 agents which can be used for some diabetics instead of
3 insulin, or in connection with some of the other researches
4 which we have been following over the years.

5 I don't know any member of my staff who
6 would be happy to take a grant of money and follow the
7 suggestions of the pharmaceutical manufacturer. I don't
8 think he would, but he would be very glad to have a contri-
9 bution if it coincided with his special interest. And
10 then, of course, the results, whatever they are, must
11 always be published.

12 THE CHAIRMAN: So they are available to any-
13 body.

14 DR. BEST: They are available to any company
15 and all companies.

16 THE CHAIRMAN: They are available to all
17 companies just as much as to those who have made the dona-
18 tion?

19 DR. BEST: Yes, that is one of the rules.

20 I think those are the main points, Mr. Smith,
21 which I wish to bring to your attention. I would be glad
22 to answer any questions.

23 THE CHAIRMAN: Mr. MacLeod, have you any
24 questions that you would like to ask Dr. Best?

25 MR. MACLEOD: I don't know whether Dr. Best
26 would want to express an opinion on this. I was wondering
27 if he would care to express an opinion on the role of
28 patents in relation to research, whether they help or
29 hinder or just exactly the situation is.

30 DR. BEST: I am not quite sure. Our own



1 practice has varied over the years.

2 When the first practical discovery was made
3 in our group, the discovery of insulin, it was patented
4 and we gave the University of Toronto, for one dollar,
5 the patent, those of us concerned.

6 Then the University gave away the rights
7 for insulin in all countries of the world with no recom-
8 pense at all, except in the United States which was near
9 enough so that every batch of material could be standar-
10 dized. There was a royalty or testing fee, if you like,
11 on insulin, made by those companies. They sent a sample
12 of every batch here.

13 We set up a laboratory for testing and it
14 was staffed by about 20 people, I think, and that has gone
15 on to this day.

16 Then any surplus was put into a reserve fund
17 for the protection of the patent and copyrights all over
18 the world, and part of that was given immediately for
19 research under Dr. Banting's direction and under mine, and
20 some of it went to Dr. Collip.

21 That was the procedure with another product,
22 "Heparin" which we purified and used first in the preven-
23 tion of thrombosis, and there was no patent taken at all.

24 Then a third thing I can think of that might
25 have a practical use is the discovery of a new vitamin.
We took no patent on that at all from the University.

27 I know the practice the world over, but it
28 varies, so that I have difficulty in making up my mind
29 what is the proper procedure.

30 I have found it slightly embarrassing when I



1 went to someone - and I don't do this very often - and
2 asked them for money for research and they said, "You
3 had it in your own hands. You could have had eight
4 million dollars or nine million dollars a year if you had
5 kept this thing, but you people give those away."

6 I think giving them away is the right thing
7 if you are medically trained. I think it is necessary.

8 THE CHAIRMAN: You are talking as a doctor,
9 and not as a manufacturer.

10 DR. BEST: That's right, I am not talking
11 as a manufacturer. I am not sure about manufacturers.
12 I don't know. I suppose patents are valuable to them.
13 I know in some matters they know how to do some things
14 that are more valuable than the patent.

15 THE CHAIRMAN: Patenting drugs in Canada
16 represents patenting a process?

17 DR. BEST: A process only.

18 THE CHAIRMAN: It would seem to involve a
19 great deal of know-how.

20 DR. BEST: Yes. I don't have any final
21 opinion on this matter. I think it is handled in diffe-
22 rent countries in different ways. I think my reaction to
23 it would be a little different if I were a chemist working
24 in a pharmaceutical company than as a professor of the
25 University with a medical outlook. I am quite sure of it.

26 MR. MACLEOD: You spoke of the know-how
27 being sometimes more important than the other factors.

28 DR. BEST: Yes.

29 MR. MACLEOD: Would this have a bearing on
30 compulsory licensing in this way, that an unwilling



1 licensor if he was forced to give the license on his
2 patent, could not pass along the know-how?

3 DR. BEST: I suppose that would be quite
4 possible.

5 MR. MACLEOD: Do you think that would be an
6 important factor in the value of the compulsory license to
7 the licensee?

8 DR. BEST: I should think it might play a
9 very important role.

10 MR. MACLEOD: I suppose it would depend upon
11 the particular product and so on?

12 DR. BEST: Yes. I can remember one instance
13 after the war that a group in England had know-how to sell
14 to people on this side of the Atlantic, and they wanted
15 several million dollars for it. The unfortunate thing
16 about this know-how, people do not have the money for it.
17 If they keep off and resist the temptation to acquire it,
18 they often can learn it themselves and save the money.

19 THE CHAIRMAN: In that case, it is not worth
20 several million dollars?

21 DR. BEST: No, it is not worth that.

22 MR. MACLEOD: There is one other point that
23 you might know something about, Doctor. It was suggested
24 that for a number of years by common practice most vaccines
25 were not patented, but that in recent years it has been
26 the practice to patent new discoveries in the vaccine
27 field. Do you know anything about that situation?

28 DR. BEST: Well, I just know what happened
29 in the Connaught Laboratories during my time. I think
30 there were no patents on the vaccines that were made then.



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1 Perhaps they were not patentable. They were not called
2 "vaccines". For diphtheria it was antitoxin, tetanus
3 toxoid and those things, as far as I know those were not
4 patented. I don't know what happened with the new vaccines,
5 the polio vaccines. I think in Canada it would be more
6 a question of patenting a process. You could not patent
7 a vaccine.

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/EMT/hm

1 MR. MacLEOD: Dr. Best, would you care to
2 express any opinion on the situation with respect to most
3 basic drugs being imported from the point of view of
4 Canada's national security and things like that? For
5 instance, I understand that penicillin is no longer
6 manufactured in Canada.

7 DR. BEST: Well, we have the know-how
8 certainly to make penicillin in Canada, and it was made
9 here for a long time. I would think that there are at
10 least two groups that are perfectly capable of making
11 penicillin, but if we were in the process of making it,
12 it would take some time to catch up in the case of an
13 emergency. Of course I think in general the more indepen-
14 dent we are, the safer.

15 MR. MacLEOD: That was the point I was
16 getting at. Do you think a certain amount of manufacture
17 should be carried on here anyway regardless of its cost?

18 DR. BEST: Well, I have been chairman of
19 the medical committee of the Defence Research Board ever
20 since it was formed, and that question has come up again
21 and again, and I think there would be occasions particularly
22 for materials that would be needed in an emergency where
23 it would be justifiable to subsidize a pilot plant to
24 keep it running in case our supplies from other sources
25 were cut off.

26 MR. MacLEOD: I think those are all the
27 points I wanted to mention.

28 THE CHAIRMAN: Apart from Institutes
29 which you have been connected with, it seems to be the
30 case that a great majority of research in the field of



1 drugs has been carried on with respect to Canada by their
2 parent companies elsewhere, largely in the United States.
3 We have been told that that is likely to change, or perhaps
4 it is even beginning to change. I wondered if your
5 experience indicates any noticeable change in that direction.

6 DR. BEST: Yes. Without giving and without
7 being able to give you any figures, I would think that
8 the volume and the importance of research by these sub-
9 sidiary companies in Canada is increasing. There are some
10 good examples of accomplishments that they have made in
11 Canada.

12 THE CHAIRMAN: By using skills which are
13 developing in Canada, the total effect should be greater?

14 DR. BEST: Yes, I would think so.

15 MR. WHITELEY: Dr. Best, I recall one
16 medical practitioner, or at least one medical person who
17 gave evidence before us and suggested that a great deal
18 of research on the part of commercial companies was not
19 so much directed to advancing knowledge in the medical
20 field as finding a product which could be sold in competition
21 with something very similar.

22 Have you any opinion as to the general
23 direction of research?

24 DR. BEST: I suppose that companies would
25 naturally conduct research which would be in their own
26 interests, but I know of many examples where, really to get
27 on with their own interests, they have to do a lot of
28 fundamental work, but that work is published, and it is
29 available to everybody.

30 I suppose it is natural that they should



1 attempt to have products which are just as good as a more
2 expensive one. Sometimes I suppose they wish to have
3 their own product although it is essentially just equal
4 to some other. I know that happens too. I think all
5 of these things take place, fundamental research, which
6 is useful to everybody, research in a narrow field designed
7 just to give them a product equally good. Of course,
8 sometimes they make products which are much better. I
9 think one could give examples of all of these things.

10 THE CHAIRMAN: A product just equally good
11 and used in almost identically the same way, there might
12 be some wastage in several companies engaging in the
13 expensive research to produce these different products when
14 there might be a single licence ---

15 DR. BEST: I don't know.

16 THE CHAIRMAN: This perhaps is getting a
17 little out of your field.

18 DR. BEST: I do not have any special knowledge
19 of that. That is what we were trying to do in Ottawa last
20 week, to make sure in support of research there was no
21 useless overlapping.

22 I have said several times if there is an
23 unsolved problem, you can't have any overlapping. Some-
24 thing that is not solved, no matter how many ways you
25 approach it, you are trying to find a solution. However,
26 that would not be applicable directly to these drug
27 companies and their research.

28 MR. WHITELEY: We have also had some
29 suggestion that in the last ten years there has been sort
30 of a burst in the results of research that result in a great



1 range of new products of very superior efficacy, and that
2 burst may have sort of tapered off recently.

3 DR. BEST: Well history is a series of
4 bursts, I think, with little lulls in between.

5 The Departments of Pharmacology in the
6 Universities, at least some years ago, had a little trouble
7 finding enough to talk about and do research on. Now,
8 as far as I know, all across the country the Departments
9 of Pharmacology are increasing in number all sorts of new
10 things for them to teach students about. It is one of
11 those eras where you can say there has been a great burst
12 of activity in pharmacology.

13 THE CHAIRMAN: I think what Mr. Whiteley
14 was referring to is the sort of idea that you get a break
15 that leads to a lot of research with several lines arising
16 out of that.

17 DR. BEST: Yes.

18 THE CHAIRMAN: Then there may be a quieter
19 period. From your experience would you say we are getting
20 a good many of these breaks and there is no sign of
21 disappearing?

22 DR. BEST: I try to keep track of the
23 number of papers on insulin over the years. I think there
24 have been about 90,000 since our first publication, and
25 there is just as much activity in the world today --
26 seven new papers on insulin every day. That has gone
27 in waves, you know. There has been a lull and then some-
28 thing has happened, and a lot of people get interested;
29 particularly in relation to these drugs which affect
30 brain cells there has been a tremendous outburst of activity



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1 now, and I hope indirectly that will pay off by having
2 fewer inmates in some of these institutions.

3 THE CHAIRMAN: Has anyone here any questions
4 they would care to ask?

5 MR. COOK: I have no questions of Dr. Best.

6 THE CHAIRMAN: Dr. Best, I know I can say
7 on behalf of the Commission we are very grateful indeed
8 for you coming here, and you have given us certain aspects
9 of research efforts that have been made that we were not
10 familiar with. Certainly it will help us to understand the
11 very important part which research is playing and has been
12 playing in the development of drugs and the effect of
13 drugs upon public health. Thank you very much.

14 DR. BEST: Thank you, sir.

15 THE CHAIRMAN: Do you wish to continue a
16 little while longer this afternoon, gentlemen? It is about
17 half past four.

18 MR. FRAWLEY: Mr. Cook has indicated to me
19 he feels he cannot possibly escape tomorrow morning, and
20 he has asked me if I will take any more than the morning.
21 I won't take any more than -- certainly I will not take
22 that time as I see it now. Mr. MacLeod's examination has
23 cleared up some things I was going to ask about, so there
24 won't be any questioning at all in the first place about
25 Mr. Cook being released at noon for the trial he has I
26 take it in the afternoon.

27 Mr. MacLeod has just given me the bad news,
28 the Ontario College of Pharmacy can't come until Friday.

29 THE CHAIRMAN: We have had that news for
30 some days. What was worrying us was what were we going to



1 do on Thursday. Now we find we have something to do.
2 However, do you wish to proceed this afternoon a while
3 longer? As far as we are concerned, it would appear there
4 would be no difficulty about concluding with all the
5 questioning arising out of the Pharmaceutical Association
6 at noon tomorrow. If that is satisfactory to you, we
7 could adjourn now rather than launch into a series of
8 questions and only just get started.

9 MR. COOK: The only comment I would make,
10 Mr. Chairman, and again I do not seek to argue a point, I
11 am losing some of my people; their business interests are
12 calling them away, and some who are still remaining will
13 not be able to be here tomorrow, and that may have some
14 significance.

15 MR. FRAWLEY: I am certainly not going to
16 finish, and I didn't mean now that my friend puts it that
17 way ---

18 MR. COOK: I am not suggesting my friend was
19 going to be finished tonight.

20 THE CHAIRMAN: We could not stay indefinitely.
21 In fifteen minutes or half an hour we would only just get
22 started.

23 MR. FRAWLEY: You have just intimated you
24 would not stay indefinitely. It does not matter about me.
25 I would stay right through until we finished this evening
26 if that was going to help anybody.

27 THE CHAIRMAN: It is not just up to the
28 Commission. It is up to other people. A five-hour day
29 of hearings is about enough for the reporters as a rule,
30 and daily transcript, and where counsel are involved, they



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1 have generally other commitments. Five hours in a day is
2 about all we can ask them to stay. If we could finish in
3 a reasonably short period of time, I would be prepared to
4 go ahead, but I think we would just get nicely started, and
5 there would not be very much to be gained.

6 We will adjourn until tomorrow morning.

7

8 ---Whereupon the hearing adjourned until 10 a.m.,

9 Thursday, October 26th, 1961.

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3 INQUIRY UNDER SECTION 42

4 OF THE COMBINES INVESTIGATION ACT

5
6 Relating to the manufacture, distribution and sale
7 of drugs

8
9 By Director of Investigation and Research

10 Combines Investigation Act

11
12 COMMISSION:

13 C. RHODES SMITH, Q.C. -- Chairman

14 A.S. WHITELEY, M.A. Member of the
 Commission

15 PIERRE CARIGNAN, Q.C. Member of the
 Commission

16
17 F. N. MacLEOD Combines Officer,
 representing the Director of Investigation
 and Research

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19
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21 Proceedings of hearings commencing at
22 10 a.m., Thursday, October 26th, 1961,
23 et seq in the City of Toronto, in the
24 Province of Ontario.

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Toronto, Ontario
October 26th, 1961.

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2 --- On commencing at 10 a.m.

3 MR. FRAWLEY: Mr. Turnbull, I would like
4 to discuss with you a little bit of arithmetic on an
5 illustrative prescription calling for a \$10.00 purchase of
6 a drug. It would be, let us assume, one of the broad
7 spectrum antibiotics or one of the ataractics or one of
8 the corticosteroids. As I understand the discounting
9 system, the retail pharmacist would have paid \$6.00 for
10 that drug?

11 MR. TURNBULL: Not necessarily Mr. Frawley
12 but he may have paid \$6.00 for it. It could range from,
13 shall we say, \$7.50 to \$6.00.

14 MR. FRAWLEY: From \$7.50 to \$6.00?

15 MR. TURNBULL: That is correct.

16 MR. FRAWLEY: What you mean then \$6.00 is
17 the 40% that I have heard about? You say that it could
18 be down to what would \$7.50 be? Thirty?

19 MR. TURNBULL: You are talking of a drug,
20 a hypothetical drug that has a list price of \$10.00 and
21 the most frequent discount that might be available on that
22 \$10.00 item would be 40% which would take it down to \$6.00,
23 yes.

24 There are quite a number that are available
25 to the retail pharmacist at the 25% discount, 30%, 33-1/3,
26 35 or possibly 40.

27 MR. FRAWLEY: As a matter of fact, I didn't
28 expect to discuss this with you now but as a matter of
29 fact going to the table near the end of your exhibit ---

30 MR. TURNBULL: Page 103.



1 MR. FRAWLEY: Page 103 you find a remarkable
2 consistency in Alberta with regard to the prescription
3 drugs?

4 MR. TURNBULL: There are a limited number
5 of outlets in Alberta I believe Mr. Frawley.

6 MR. FRAWLEY: There are what?

7 MR. TURNBULL: There are a limited number
8 of outlets from which to determine figures in a survey of
9 this nature to provide for minimums and maximums, of
10 course.

11 MR. FRAWLEY: Mr. Turnbull, I am only
12 asking you, I want to discuss that with you a little later.
13 I just thought that showed in Alberta there is a pretty
14 uniform situation. There is no variance at all on
15 purchases direct from the manufacturer and there is a
16 negligible one per cent variance when the pharmacist buys
17 from the wholesaler. Isn't that a correct interpretation
18 of that table?

19 MR. TURNBULL: Yes, I believe that is how
20 I would interpret it, yes.

21 MR. FRAWLEY: I want to know to what extent
22 a person can quite properly treat the 40% discount which
23 the Director referred to on page 89, paragraph 152 -- the
24 40% discount is the going discount in the retail drug
25 trade?

26 MR. TURNBULL: It is the most usual discount.

27 MR. FRAWLEY: Then we won't take any time
28 on preliminaries. So now then let's deal with this
29 arithmetic. A retailer will have paid \$6.00 for that \$10.00
30 drug which the physician has prescribed, and I put it to



1 you -- again those are my instructions -- that the going
2 discount of the wholesaler in Alberta is 16, and perhaps,
3 to be exact, that should be 16-2/3% of the price to the
4 druggist. You don't challenge that I take it?

5 MR. TURNBULL: Yes sir, I do.

6 MR. FRAWLEY: You challenge that?

7 MR. TURNBULL: Oh yes sir.

8 MR. FRAWLEY: Then, Mr. Chairman, I will
9 at some appropriate time verify what I am now giving to
10 you. I am asking you for the purpose of this questioning
11 to assume -- do you know the National Drug in Alberta?

12 MR. TURNBULL: May we clarify this point
13 first, Mr. Frawley?

14 MR. FRAWLEY: Yes, I want it clarified
15 because if there is any dispute as to the 16 or 16-2/3
16 then I am going to ask you to assume it with me because
17 that is according to my instructions. I can establish
18 that.

19 MR. TURNBULL: I think that for the purpose
20 of the Commission and others we should clarify this point:
21 The discount normally made available to wholesalers is
22 16-2/3 plus possibly two for cash, and this type of thing
23 but that 16-2/3 is not necessarily in addition to the
24 retailer's direct purchase price.

25 Let me use for an example the retailer in
26 buying direct, and hypothetically again, may obtain 40%
27 discount, in this case we are using here. On the other
28 hand, the wholesaler from that same company might only
29 obtain a 45% discount, or he might obtain a 50% discount
30 or he might obtain only the 40% discount. When he obtains



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3 to be exact, that should be 16-2/3% of the price to the
4 druggist. You don't challenge that I take it?

5 MR. TURNBULL: Yes sir, I do.

6 MR. FRAWLEY: You challenge that?

7 MR. TURNBULL: Oh yes sir.

8 MR. FRAWLEY: Then, Mr. Chairman, I will
9 at some appropriate time verify what I am now giving to
10 you. I am asking you for the purpose of this questioning
11 to assume -- do you know the National Drug in Alberta?

12 MR. TURNBULL: May we clarify this point
13 first, Mr. Frawley?

14 MR. FRAWLEY: Yes, I want it clarified
15 because if there is any dispute as to the 16 or 16-2/3
16 then I am going to ask you to assume it with me because
17 that is according to my instructions. I can establish
18 that.

19 MR. TURNBULL: I think that for the purpose
20 of the Commission and others we should clarify this point:
21 The discount normally made available to wholesalers is
22 16-2/3 plus possibly two for cash, and this type of thing
23 but that 16-2/3 is not necessarily in addition to the
24 retailer's direct purchase price.

25 Let me use for an example the retailer in
26 buying direct, and hypothetically again, may obtain 40%
27 discount, in this case we are using here. On the other
28 hand, the wholesaler from that same company might only
29 obtain a 45% discount, or he might obtain a 50% discount
30 or he might obtain only the 40% discount. When he obtains



1 only the same price as the retailer, and this does occur,
2 he will adjust the prices at which he sells to the retailer
3 so that he may realize the profit that he deems necessary
4 for himself.

5 In other words, he may sell to the retailer,
6 shall we say, at 30% which is approximately in the
7 calculations the 16, or he may sell at 28% to obtain his
8 normal gross markup but it would not be correct to say that
9 in every instance where the retailer obtains 40% direct
10 from the manufacturer the wholesaler receives that 40%
11 and an additional 16-2/3. Indeed, I would say it would
12 be incorrect to say that that happened in the majority of
13 instances.

14 MR. FRAWLEY: Well now, as I say, I want
15 to discuss this with you on an assumption basis because
16 my instructions from the Minister of Health of Alberta,
17 after having made enquiries, very thorough enquiries I
18 am assuming, that the wholesale price and in Alberta
19 National Drug is written in as a sort of memorandum so
20 that I know what he is talking about.

21 MR. TURNBULL: I used to be an employee of
22 National Drug and Chemical Company at one point.

23 MR. FRAWLEY: Then you know they are, without
24 making comparisons, they are a large wholesale supplier
25 in Alberta?

26 MR. TURNBULL: They are one of them, yes.

27 MR. FRAWLEY: Now I am putting it to you
28 that the wholesale price is 16 -- I am saying 16 for easy
29 figuring, but I am putting this arithmetic to you, Mr.
30 Turnbull, and if it is wrong then when the Commission comes



1 to assessing it, it will be handled accordingly, but at
2 the same time I propose to establish that that is the
3 structure in Alberta. I won't discuss with you the
4 difference in our structure with the rest of Canada right
5 now but for this question the retailer will pay on the
6 basis of a 40% discount. He will pay \$6.00 for this
7 \$10.00 prescription drug. The wholesaler will pay \$5.04
8 using my 16% discount and \$5.04 then is what the manufacturer
9 receives for that \$10.00 prescription.

10 Now, Mr. Turnbull, I put it to you that
11 50% of the consumer's price has gone right there between
12 the wholesaler's intake door and the retailer's counter
13 when the patient obtains a prescription, obtains the drug.

14 MR. COOK: I suppose nobody can question
15 the arithmetic, except to the extent of \$4.00, mathematical
16 calculation.

17 MR. FRAWLEY: I put it to you that that is
18 according to my instructions the price structure in Alberta
19 for goods that are bought from the wholesaler. Do you
20 challenge that?

21 MR. TURNBULL: Yes sir.

22 MR. FRAWLEY: You challenge that. What
23 have you got to support you in your challenge?

24 MR. TURNBULL: For the purpose of your
25 assumption, you are correct but only for illustrative
26 purposes sir. Unless you wish to stipulate the specific
27 item, I am sorry, but I do not believe that you can assume
28 that all pharmaceuticals are available on such a price
29 structure.

30 MR. FRAWLEY: Let me stop you there because



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2 he will adjust the prices at which he sells to the retailer
3 so that he may realize the profit that he deems necessary
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25 assumption, you are correct but only for illustrative
26 purposes sir. Unless you wish to stipulate the specific
27 item, I am sorry, but I do not believe that you can assume
28 that all pharmaceuticals are available on such a price
29 structure.

30 MR. FRAWLEY: Let me stop you there because



1 I am not concerned -- I am concerned with broad spectrum
2 antibiotics, with corticosteroids and with tranquilizers.
3 In other words, I am concerned with the commodities which
4 the Director under the Combines Investigation Act investi-
5 gated and I have no brief outside of that so let's confine
6 ourselves now to what I am talking about. Therefore,
7 confining yourself to these big three, the antibiotics, the
8 broad spectrum antibiotics, the tranquilizers and the
9 corticosteroids I put it to you that my assumption is
10 correct.

11 MR. TURNBULL: I am sorry, I cannot agree with
12 you.

13 MR. FRAWLEY: Now then you want to clarify
14 it again? I thought you had brought it down to these
15 kind of drugs.

16 MR. TURNBULL: No, you cannot take it on a
17 drug basis. You can take it on a company basis. Have you the
18 name of a company that you wish to use for illustrative
19 purposes?

20 MR. FRAWLEY: No, not at this stage. I am
21 simply putting it to you that if you accept, if you adopt,
22 if you use the 40% off to the retailer and the 16% off to
23 the wholesaler, which I put it to you according to my
24 instructions is the price structure for these three kind
25 of drugs in Alberta, then my statement which I put to you
26 is correct, that 50% of the consumer's dollar has gone
27 between the wholesaler's intake door and the retailer's
28 counter and that must be so?

29 MR. TURNBULL: No sir.

30 MR. FRAWLEY: I say it must be so upon the



1 assumption that I have made, that 40% is the retailer's
2 discount and 16% is the wholesaler's discount.

3 MR. TURNBULL: Well, Mr. Frawley, I don't
4 really want to argue with you. I agree with you on your
5 assumption but I am merely attempting to point out that
6 this is not the case in specific instances.

7 Now if I may, Mr. Chairman, I believe that
8 Mr. MacLeod has a catalogue, or had when Cyanamid made its
9 presentation and in the front pages of that catalogue, if
10 it is the same one as I am thinking of, we can show Mr.
11 Frawley that this just isn't so. I don't know that it is
12 necessary to do this, but I believe he will find the same
13 thing in the case of the Squibb Company.

14 THE CHAIRMAN: Does Cyanamid sell to whole-
15 salers?

16 MR. TURNBULL: And I believe that they
17 checked into Parke Davis.

18 MR. FRAWLEY: Mr. Turnbull, I agree it is
19 quite obvious that if the retail pharmacist is buying from
20 the manufacturer at 40% off list and the wholesaler is not
21 in the transaction at all that then not so much of the
22 consumer dollar has disappeared at the moment that he takes
23 the prescription off the counter. I quite agree to that
24 extent, and you would agree with that?

25 MR. TURNBULL: No sir.

26 MR. FRAWLEY: Well, I have to try to be
27 patient. If the discount is 40% that the retailer obtains
28 when he buys direct from the manufacturer, I put it to
29 you that 40% of the consumer dollar has gone when he walks
30 out of the drug store. It has gone to the retail pharmacist.



1 MR. TURNBULL: It has gone to the retail
2 pharmacist, and all the people that he employs and all the
3 people that he pays his bills to, yes sir. That is correct.

4 MR. FRAWLEY: Is that the only reason that
5 you disagreed with me a moment ago?

6 MR. TURNBULL: No sir.

7 MR. FRAWLEY: I hope not. I hope we are
8 not starting to quibble Mr. Turnbull.

9 MR. TURNBULL: No sir. I merely am trying
10 to establish, not from the viewpoint of being argumentative,
11 that this is not correct: That the wholesale discount is
12 necessarily in addition to what the retailer would pay for
13 that same product if he was buying direct.

14 MR. FRAWLEY: I quite understand, and I told
15 you, I put it to you if the retail pharmacist is buying
16 direct from the manufacturer then we are only concerned
17 with a 40% margin?

18 MR. TURNBULL: Right.

19 MR. FRAWLEY: But if the retailer is dealing
20 in Alberta with Alberta National Drug and Alberta National
21 Drug is dealing with the manufacturer, which I put to you
22 that it is a case of 40% plus 16. That is what I am putting
23 to you.

24 MR. TURNBULL: I am putting to you sir
25 that is not correct.

26 MR. FRAWLEY: Well then, if that is as far
27 as we can get, we will see from a close precise examination
28 of the Alberta price structure, which I propose to do,
29 what the effect is. You say there are some differences
30 that come in there between the manufacturer and the retailer



1 even when the wholesaler is being used?

2 MR. TURNBULL: Yes.

3 MR. FRAWLEY: Now then, if the pharmacist
4 charges a prescription fee of \$1.00, you add that to what
5 I put to you as an illustration, then the consumer is
6 paying \$11.00 to have that prescription filled?

7 MR. TURNBULL: Placing emphasis on that
8 word "if" you are correct.

9 MR. FRAWLEY: If he pays it you mean?

10 MR. TURNBULL: If the pharmacist charges
11 a dispensing fee of \$1.00, yes.

12 MR. FRAWLEY: I will turn it around:
13 Wherever the retail pharmacist charges a dispensing
14 fee of \$1.00 or 75¢ then the purchaser of the prescription
15 pays an extra \$1.00 or 75¢?

16 MR. TURNBULL: Wherever that happens, that
17 is correct.

18 MR. FRAWLEY: And you know that this is the
19 practise of many retail pharmacists today in Canada?

20 MR. TURNBULL: I believe it is, yes.

21 MR. FRAWLEY: Now, then wherever that
22 obtains then the consumer, in my instance of the \$10.00
23 prescription, is paying \$11.00 and so again out of the
24 consumer's \$11.00 the pharmacist gets \$11.00 minus \$6.00
25 that he pays to the wholesaler or \$5.00? That doesn't
26 trouble you, does it?

27 He picks up \$11.00 from the patient with
28 the prescription and he has paid \$6.00, using the 40%
29 discount, he has paid \$6.00 for the prescription so that
30 he retains \$5.00 does he not, as his gross margin or



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1 markup?

2 MR. TURNBULL: That is his gross margin,
3 yes.

4 THE CHAIRMAN: That is simply a matter of
5 arithmetic.

6 MR. FRAWLEY: That is right sir.

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1 MR. FRAWLEY: So that he has, on that basis,
2 he has used up what he gets out of this 45% of the consu-
3 mer's dollar on that basis?

4 MR. TURNBULL: I will take your figures.

5 MR. FRAWLEY: You agree with that?

6 MR. TURNBULL: I will take your figures.

7 MR. FRAWLEY: And the wholesaler, if the
8 wholesaler is still in this picture of a ten-dollar pres-
9 cription plus \$1 or the \$11 paid by the consumer, the
10 wholesaler gets \$6 less \$5.04 or \$1.04 or 9½% of the
11 consumer's dollar?

12 MR. TURNBULL: He will get \$1, I think.

13 MR. FRAWLEY: Now, you spoke yesterday that
14 there is some possibility that the 40% isn't considered
15 to be sufficient. Did you contemplate that the 40% would
16 be raised to 50% without increasing the list price?

17 MR. TURNBULL: It would be a most desirable
18 thing, sir.

19 MR. FRAWLEY: You have been discussing that
20 in your organization and I just wanted to know whether or
21 not it was an increase from 40 to 50 without increasing
22 the list price.

23 MR. TURNBULL: If at all possible, yes.

24 MR. FRAWLEY: I mean, surely it would be by
25 a last resort to increase the list price, wouldn't it?

26 MR. TURNBULL: Well, I don't think that
27 entered into our discussions because that end of it would
28 be up to the individual manufacturer. We are primarily
29 concerned in the needs of the pharmacy practitioner at
30 that point and if the manufacturer was able to do as he



1 had expressed without increasing his suggested list price
2 from which he makes all his trading calculations that, of
3 course, would be a most desirable thing.

4 MR. FRAWLEY: Yes.

5 MR. TURNBULL: I presume some might be able
6 to do that whereas some might not be able to do it.

7 MR. FRAWLEY: The whole scheme has to be
8 done actually by the manufacturer increasing the discount
9 and is a matter for the manufacturer to establish?

10 MR. TURNBULL: Oh, yes.

11 MR. FRAWLEY: Yes, and I really wondered
12 whether or not you had any contemplation that that would
13 necessarily mean an increase in the list price?

14 MR. TURNBULL: Not necessarily.

15 MR. FRAWLEY: Not necessarily. Wouldn't you
16 agree with me it would be pretty unthinkable to increase
17 the list price of these antibiotics, the broad spectrum
18 ones, the corticosteroids and the others at this particular
19 juncture? Would that not be pretty difficult?

20 MR. COOK: To whom, to the manufacturer?

21 MR. FRAWLEY: Unthinkable to this witness.

22 MR. COOK: Would he have an opportunity...

23 MR. FRAWLEY: What is your answer, Mr.
24 Turnbull?

25 MR. TURNBULL: Would you like to go over the
26 question?

27 MR. FRAWLEY: Would it not be, in your
28 opinion, completely unthinkable at this juncture of the
29 drug industry in Canada to increase the list price of
30 antibiotics, tranquilizers and corticosteroids?



1 MR. TURNBULL: May I ask why I should think
2 this completely unthinkable?

3 MR. FRAWLEY: Because of the outcries, in
4 the words of Mr. Thompson, the anguished outcry.

5 MR. COOK: I don't think this witness should
6 answer on public relations, a political judgment.

7 MR. FRAWLEY: I don't understand my friend's
8 objection. Who could be a better witness than the Manager,
9 Director of the Pharmaceutical Association to say whether
10 or not there could be now, in the present state of affairs,
11 an increase? Everybody is talking about a decrease. I
12 want to know how practical or sensible he thinks an
13 increase would be in this case.

14 THE CHAIRMAN: It is really a matter of
15 opinion.

16 MR. FRAWLEY: Of course it is.

17 MR. TURNBULL: I have expressed the opinion
18 it would be most desirable that the prices remain at their
19 present level, or be reduced. I have expressed my opinion,
20 Mr. Frawley. You have said a public outcry. Where is the
21 public outcry?

22 MR. FRAWLEY: I haven't made any outcry.
23 Mr. Thompson came here with his brief for Cyanamid and
24 talked about the anguished outcry. You take some comfort
25 from the empty chairs? We will speak of that.

26 MR. TURNBULL: Mr. Frawley, I take absolutely
27 no comfort from the empty chairs. It is of exceedingly
28 great concern to me that this time last year there was an
29 awful lot of noise going on in the public and the public
30 press and that certainly is no evidence that anything has



1 happened except it has withered on the vine right now.

2 MR. FRAWLEY: I simply put it to you in
3 your brief - I don't know what particular paragraph, it
4 suggests there is a need for a better understanding of the
5 position of the retail pharmacist and perhaps even of the
6 manufacturer. I simply put it to you that the need for
7 that kind of rapport - I put it to you you just wouldn't
8 be party to an increase of price. You disagree with that?
9 You wouldn't be a party to it.

10 MR. TURNBULL: I wouldn't want to say a
11 definite yes or a definite no to a statement of that
12 nature.

13 MR. FRAWLEY: Because, I put it to you, Mr.
14 Turnbull, that 40% of the consumer's dollar - you just
15 wouldn't want to be left in the position of taking any
16 more than 40% of the consumer's dollar.

17 MR. COOK: The witness answered the question.
18 I object to political statements.

19 THE CHAIRMAN: I think you have as much as
20 you are going to get on this.

21 MR. FRAWLEY: I want to be alert to my
22 friend's objection. Did I hear him say political objec-
23 tion?

24 MR. COOK: Not in any derogatory way.

25 MR. FRAWLEY: I hope, and I might as well
26 have my position understood now as at any other time, I
27 understand that the Province of Alberta was a welcome
28 participant in these proceedings. If I am coming here
29 to pursue political purposes I have misunderstood my
30 purpose. I want to record my resentment and the resentment



1 of the Premier of Alberta for that kind of remark from
2 the counsel for the Pharmaceutical Association.

3 THE CHAIRMAN: I don't think Mr. Cook
4 meant it that way. I don't think he meant party political
5 activity. I think he meant political in the sense of
6 public reaction and the effect that might have on judg-
7 ment.

8 MR. FRAWLEY: If I have any political
9 interest here it is all pro bono publico, if my friend
10 calls that political interest. I want to discuss with
11 you what you say on page 84 and follow up on page 110
12 and 111, the average price of prescriptions in 1960. The
13 first thing I want to say about that is looking at page
14 84 it does appear that the average price of prescriptions
15 as you have calculated has increased, has almost doubled,
16 in that general neighbourhood, between 1951 and 1960.

17 MR. TURNBULL: Not almost doubled, 88.4%,
18 sir.

19 MR. FRAWLEY: What percent?

20 MR. TURNBULL: 88.4.

21 MR. FRAWLEY: 88.4, while we are talking
22 about that I hope...

23 MR. TURNBULL: 82.1.

24 MR. FRAWLEY: A great, a large percentage
25 of all prescription drugs costs more than the average?

26 MR. TURNBULL: I believe that is borne out
27 by other tables we presented in here. Just a minute, on
28 the basis of a 1957 survey of some 42,545 prescriptions
29 from 182 pharmacies, in 1957 the average price was \$2.61
30 and according to that survey 58.5% of all prescriptions



1 was dispensed at \$2.50 or less; in other words, very close
2 to three-fifths of all prescriptions were dispensed below
3 average.

4 MR. FRAWLEY: Well then, Mr. Turnbull, you
5 would have no difficulty in agreeing with this statement
6 which I took from the article on the high cost of drugs
7 in the Kiplinger Magazine of August, 1960: on the
8 average a prescription your doctors writes and you get
9 filled at the drugstore costs \$3.08 - might I stop there
10 and call attention to the identity between American
11 average price and the Canadian average price.

2 MR. TURNBULL: Same year, Mr. Frawley?

3 THE CHAIRMAN: Is that for the same year,
4 Mr. Frawley? That might have some importance because the
5 average has been going up almost every year.

6 MR. TURNBULL: The Kiplinger Magazine
7 referred to 1959 figures in the United States, Mr.
8 Chairman.

9 MR. FRAWLEY: He talks about, he just
10 talks about ten years ago. I can't do any more. I will
11 try to document it or I would even go further - I
12 certainly don't mind putting myself out - I wouldn't be
13 putting myself out, I will try to find out from the person
14 who wrote the article what period he used.

15 MR. TURNBULL: If I may help you, Mr.
16 Frawley, referring to page 111 I believe that the article
17 refers to the American figures for 1959.

18 MR. FRAWLEY: The American figures, you say,
19 are 1959, page 111?

20 MR. TURNBULL: Yes.



1 MR. FRAWLEY: \$3.08 on there. \$3.08 in
2 1959. He may even - well, let us assume he is talking
3 about 1959 and you are talking about 1960. On the average
4 the prescription your doctor writes and you get filled at
5 the drugstore costs \$3.08. That hardly sounds expensive
6 even recognizing that it is an average of high cost and
7 low cost prescriptions. But 10 years ago the average was
8 \$1.60 so the average prescription prices have only doubled
9 in the last decade. Moreover 39% of all prescriptions
10 cost more than the average.

11 You say you are not prepared to disagree,
12 in fact you agree that the percentage 39% of all prescrip-
13 tion costs more than average?

14 MR. TURNBULL: That is very close to the
15 1957 survey that was done by Professor Fuller. It would
16 indicate in Canada in 1957 some 40% of all prescriptions
17 were above.

18 MR. FRAWLEY: There certainly is an identity,
19 apparently, in the retail marketing of prescriptions in
20 the United States and in Canada that would seem to be
21 borne out. Pausing there for a moment, I want to put this
22 to you: did you make a survey of the broad spectrums,
23 the corticosteroids and the tranquilizers in this kind
24 of prescription?

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1 MR. TURNBULL: It is not on prescriptions,
2 sir, regardless.

3 MR. FRAWLEY: It is not on prescriptions
4 regardless.

5 MR. TURNBULL: Regardless of their thera-
6 peutic category or their drug classification.

7 MR. FRAWLEY: In other words you did not
8 confine your survey to the kind of allegedly high cost
9 drugs that the Director was investigating?

10 MR. TURNBULL: Our survey was not conducted
11 for the purpose of answering the Director's Statement.
12 Our survey has been carried on for 19 years, sir.

13 MR. FRAWLEY: I am just saying that it does
14 include - you are saying to me, I am not saying - that it
15 does include all of the prescription drugs, high cost and
16 low cost?

17 MR. TURNBULL: Oh yes.

18 MR. FRAWLEY: In other words just as an
19 illustration, you have put in the same mix a prescription
20 for 50 tablets of Parke-Davis' Colchicine which costs
21 \$1.25 and \$9.40 for 30 tablets of Merck's Decadron which
22 also is an anti-inflammatory agent for arthritis.

23 MR. TURNBULL: I presume there are some
24 prescriptions for those items included in the average
25 figures that are surveyed in this.

26 THE CHAIRMAN: Mr. Turnbull, to make this
27 quite clear, in your survey have you made any division
28 at all at any stage between high cost and low cost pres-
29 cription drugs, above or below a certain point, and subse-
30 quently added them together, or have you just taken all



1 prescriptions, totalled them, and divided by the number
2 of prescriptions?

3 MR. TURNBULL: No, our survey form is
4 basically a survey of retail pharmacy operations and
5 then, across the bottom of the questionnaire page, pres-
6 cripition information is requested, new prescriptions,
7 number, and total value; repeat prescriptions, number,
8 and total value, that is all, sir.

9 There has been no individual survey of
10 actual prescriptions in Canada, that is, price-wise.

11 There have been surveys such as this one
12 mentioned in our presentation relating to generic termi-
13 nology and that type of thing. There have been small
14 surveys conducted from time to time, I believe, related
15 to the ingredients, but none that are available to me that
16 I can think of. I believe that there might be some of
17 that information from some of the American surveys, I am
18 not too sure, and I know that such statistics are avai-
19 lable from the Medical Surveys Division of the Saskat-
20 chewan Department of Health, but it is not a good survey
21 for the reason that this is an indigent ward, old-age
22 pensions, blind pensions, and mothers' allowances and
23 such groups. So it would not necessarily pertain to the
24 overall picture.

25 THE CHAIRMAN: There has been no survey
26 made which would indicate how many drugs are over \$10,
27 for example, or what proportion of the drugs are within
28 a dollar, say, of the average.

29 MR. TURNBULL: No.

30 THE CHAIRMAN: It seems to me if you take



1 one dollar above the average you would not have too large
2 an average left, and there is no way of indicating what
3 the picture is in that respect?

4 MR. TURNBULL: The 1957 survey indicated
5 that 1.1% of all prescriptions was priced at \$10 or
6 higher, but it did not indicate the ingredients of those
7 prescriptions.

8 THE CHAIRMAN: No.

9 MR. FRAWLEY: I put it to you, that you
10 would get quite a different picture if you analyzed
11 prescriptions such as I will now call to your attention:
12 a prescription for 30 of Lederle's Aristocort which would
13 cost \$12.11, or a prescription of Schering's Meticorten
14 which would cost \$7.10, or a prescription for 30 of
15 Schering's Deronil which would cost \$9.40, or of Merck's
16 Decadron which would cost \$9.40 or of Upjohn's Medrol
17 which would cost \$12.13 for 30 in 4-milligram or \$6.05
18 in 2-milligram, or if you had included a prescription for
19 Schering's Trilafon which would cost \$4.30 for 50, or a
20 prescription for Largactil which would cost \$2.20 for 20,
21 or a prescription for Bristol's Polycycline which would
22 cost \$7.90 for 16, or of Tetrex which would cost \$5.68
23 for 25, or of Lederle's Declamycin which would be \$7.90
24 for a bottle of 16, or of Lederle's Aureomycin which
25 would be \$3 for a bottle of 25, or of Pfizer's Cosa-terra-
mycin which would be \$6.75 for 25.

27 I put it to you that if you had made a
28 survey of those drugs, then the \$3.06 would be considerably
29 higher.

30 MR. TURNBULL: I believe that we can



1 definitely agree with you, Mr. Frawley, and I put it to
2 you as well that if our survey related itself to age
3 groups, or related itself to sex or to families and to
4 family sizes, to financial conditions of these families,
5 whether they are welfare recipients or private people,
6 if we related this to illness categories or hereditary
7 factors of those who were using these drugs, all of these
8 things come into this, if they are wage earners as opposed
9 to self-employed people, if they on insurance schemes
10 as opposed to buying their own medication, if they are
11 going to a specialist as opposed to a general practitioner.

12 I believe that the Commission brought out
13 the need for all these areas of study yesterday in our
14 discussion, and I think they are all extremely pertinent
15 to the whole picture.

16 MR. FRAWLEY: Or if you related it to the
17 profit that Schering was making on the Meticorten, or
18 the profit that Merck was making on the Decadron, or the
19 profit that Lederle was making on the Aristocort, that
20 also might be a very interesting factor to have in the
21 general mix.

22 MR. TURNBULL: Yes, and if we related it to
23 whether these companies had been involved in research at
24 any point, or were going to be involved in research for
25 some other point, whether these companies were instru-
26 mental in making the good of the products available.
27 Let us not forget any of these factors. I am not blowing
28 the whistle or waving the flag for anybody, let me assure
29 you.

30 MR. FRAWLEY: If you would turn to page 29



1 and page 30 of your brief where you speak about the
2 C.Ph.A. and C.P.M.A. Committee, I would like to ask you
3 something about that committee.

4 You speak about it on page 29 and you say
5 that one of your rules is to maintain a liaison with other
6 organizations of similar purpose and activity. "Such
7 liaison committees do exist, one of them being with the
8 Canadian Pharmaceutical Manufacturers' Association".

9 On page 30 you say that the committee is
10 formed to discuss and resolve problems, and you are
11 interested in both associations, and this committee does
12 not have the power of final decision.

13 In sub-paragraph 3 you say "This committee
14 shall not discuss in any manner whatsoever matters per-
15 taining to prices or discounts, or any other matter which
16 might lead to action in violation of the provisions of the
17 Combines Investigation Act or of the Criminal Code."

18 Then you proceed to indicate that you
19 discuss such matters as the research, the quality control
20 and the promotion and advertising.

21 You discuss these matters, do you? Is that
22 a fair inference to draw from the text of your brief which
23 follows on in pages 31, 32, 33 and 34?

24 MR. TURNBULL: That is not a fair inference
25 to draw from those pages, Mr. Frawley, no.

26 MR. FRAWLEY: It is not a fair inference?

27 MR. TURNBULL: No.

28 MR. FRAWLEY: So that we cannot assume
29 that you discuss - I wondered why you discuss them so
30 fully if they were not matters which had been brought to



1 the attention of this C.Ph.A. and C.P.M.A. Committee.

2 In any event you say that you don't
3 discuss those things.

4 MR. TURNBULL: I didn't say that, no. I
5 said that is not a fair inference to draw from the
6 following pages. There may be some of those problems
7 and some matters concerned in there particularly as they
8 relate to drug legislation and amendments, and I believe
9 that you realise I am searching for the advice that came
10 from the Food and Drug Directorate about last December or
11 possibly January of this year relative to proposed amend-
12 ments concerning new drugs and concerning manufacturing
13 facilities.

14 These are all of definite interest to phar-
15 macy practitioners as well as to pharmaceutical companies,
16 manufacturing companies.

17 MR. FRAWLEY: Wouldn't the prices which the
18 retailer has to pay be a matter of mutual interest?

19 MR. TURNBULL: "This committee shall not
20 discuss in any manner whatsoever matters pertaining to
21 prices or discounts, etc., etc." Mr. Chairman, if it is
22 your desire I will be sworn in this part of the evidence.

23 THE CHAIRMAN: I have not felt it was
24 necessary to swear you.

25 MR. TURNBULL: All right sir.

26 MR. FRAWLEY: Did the witness say he wanted
27 to be sworn?

28 MR. TURNBULL: I will be sworn if it is
29 desirable.

30 THE CHAIRMAN: You have not asked for it,



1 Mr. Frawley.

2 MR. FRAWLEY: I do not even know what
3 prompted the question. Sometimes a remark like that is
4 made when the witness thinks the questioner is doubting
5 his word. Do you think I am doubting your word, Mr. Turn-
6 bull?

7 MR. TURNBULL: We have stated we do not
8 discuss prices in these meetings.

9 MR. FRAWLEY: Pardon?

10 MR. TURNBULL: We have stated these liaison
11 meetings do not discuss prices under any circumstances.

12 MR. FRAWLEY: I am asking why you should
13 not. Surely I can explore that with you. Certainly I
14 see the rule. It is a rule saying - you have actually
15 put the wording, "shall". I am accepting the fact that
16 you don't. That is what I am complaining about.

17 Let us discuss it for a moment. What would
18 be wrong with you telling these manufacturers that they
19 are charging you too much for their drugs, that the list
20 price is too high, and perhaps talk about the discount,
21 too, that the suggested list price is too high? That is
22 what I am asking you. You don't need to be sworn on my
23 account. We can discuss that. Why not discuss that?

24 MR. TURNBULL: Well, possibly I should have
25 read the balance of the sentence "--or any other matter
26 which might lead to action in violation of the provisions
27 of the Combines Investigation Act or of the Criminal Code
28 or of any other law of the Dominion of Canada or of any of
29 the Provinces".

30 That is the reason, Mr. Frawley, any



1 activities which might lead to that. It is purely and
2 simply that. Regrettably we would like to, too. That has
3 been the pronouncement of the membership of my organization.
4 They would like to, certainly, but we can't.

5 MR. FRAWLEY: Are you suggesting or saying
6 to me that you have kept away from having a real hard
7 bargaining session on prices with these manufacturers
8 because you are afraid of offending them under the Com-
9 bines Investigation Act or the Criminal Code?

10 MR. TURNBULL: That could be one of the
11 reasons, yes.

12 MR. FRAWLEY: I actually want to know how
13 extraordinary this situation is. Has the Minister of
14 Justice or anyone connected with him ever suggested that
15 you must keep away from discussing bargaining with these
16 people?

17 MR. TURNBULL: He has never suggested that
18 to my knowledge. Let me put it to you this way, Mr.
19 Frawley. If you care to talk to your neighbour, but your
20 neighbour does not care to talk to you, it is not going
21 to do you much good to talk to him.

22 MR. FRAWLEY: That is what I want to bring
23 out right here.

24 MR. TURNBULL: All right sir.

25 MR. FRAWLEY: You say that you would like
26 to discuss with the manufacturers the business of getting
27 better prices, but they won't talk to you about it?

28 MR. TURNBULL: I didn't say that.

29 MR. FRAWLEY: What was the analogy between
30 you and your neighbour, then? Just make it clear to me,



1 that is all, Mr. Turnbull, or to the Commission.

2 MR. TURNBULL: I said there are several
3 occasions when we get into the field of prices and price
4 levels with which we are concered that it would be most
5 desirable from the standpoint of our membership to have
6 open discussion with the manufacturers on this very
7 problem, but regrettably there is always this difficulty
8 that such discussions might lead to actions in violation
9 of the provisions of the Combines Investigation Act or
10 the Criminal Code, etc., and therefore such discussions
11 have not taken place.

12 Now, if I can continue for one moment, in
13 our presentation we mentioned the names of the committees
14 of the Canadian Pharmaceutical Asscociation. I believe it
15 would be of interest to the Commission to know that the
16 committee which is called the Committee on Pharmaceutical
17 Economics was so named in 1954 to replace a name which
18 that same committee had held for three or four years and
19 which was entitled The Committee to Review Prices of Drugs
20 to Government Institutions, Hospitals, Etc., and we
21 changed that.

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MR. FRAWLEY: What did you say?

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MR. TURNBULL: We changed it to the more specific committee heading of Pharmaceutical economics. Now, I merely point it out to you to point out that we have recognized this problem for many, many years, this wide discrepancy in drug price levels.

7

MR. FRAWLEY: I want to give an illustration that I think will make it very clear at least what I am talking about, and I think you and I, after a bad start, are really now talking about the same thing. You say you do not discuss getting better prices, better list prices because you feel that that kind of discussion to reduce list prices would lead to some infraction of the Combines Investigation Act or the Criminal Code. That is your reason why there has been silence between the pharmacists and the sellers, the manufacturers? Is that what I am to understand?

18

MR. TURNBULL: That would be one of the points, yes, but I think you can take my statement that matters concerning price on discounts have not been entered into the agenda either prior to or during any of the meetings which have been held between C.Ph.A. and the C.P.M.A. through their liaison committee.

24

MR. FRAWLEY: I think the Commission will be interested and the people who sent me here will be interested to know this; that has a lot to do with the alleged high cost of drugs. This studied silence between the buyers and the sellers. I want to give you an example. Will you look at page 201 of the green book. There you will find the Director reports that S.K.F., Canada, buys



1 from S.K.F. in Philadelphia, Stelazine in bulk form at
2 \$1.32 per thousand in the two milligram dosage. In simple
3 calculation that is three and two-tenths cents a hundred;
4 isn't it?

5 Now, I want to have your opinion upon a
6 question I put to Mr. Walter Maday in Edmonton who is an
7 official of the Alberta Pharmaceutical Association, which
8 is your constituent member in Alberta, and after having
9 called his attention to what Smith, Kline and French pays
10 for Stelazine, and having called his attention to the
11 list prices -- and I will now do that, I will use the list
12 prices in your May 1961 where I find ---

13 MR. TURNBULL: 1961 what?

14 MR. FRAWLEY: May 1961 is the price book
15 you filed yesterday.

16 MR. TURNBULL: Volume 22.

17 MR. FRAWLEY: And there I find that this
18 2 milligram tablet Stelazine lists at \$6.25 for 50;
19 \$57.00 for 500, and using that \$57.00 and \$114.00 for 1000,
20 that is the thousand that Smith, Kline and French paid
21 \$1.32 for when they bought in bulk form from its parent
22 company in Philadelphia.

23 Now, I asked Mr. Maday if he thought there
24 was any normal discipline of the marketplace in selling
25 Stelazine from Smith, Kline and French to the retail drug
26 trade, and he said no, there is not. Do you agree with
27 Mr. Maday?

28 MR. TURNBULL: If he thought there was?

29 MR. FRAWLEY: His whole answer is ---

30 MR. TURNBULL: No, what was your question?



1 MR. FRAWLEY: I will put it to you.

2 MR. TURNBULL: If he thought there was any?

3 MR. FRAWLEY: Maybe I had better read it

4 to you. If he thought there was any normal discipline of
5 the marketplace. The page is 1055. "The Edmonton Journal
6 of 16th June of this year had an article which was headed
7 'Authoritative enquiry imperative'. And I may add this
8 enquiry"-- article is not the right word -- it was an
9 editorial, and "I will only read one sentence. The object
10 of this hearing, of course, must be to develop remedial
11 measures which would return the drug industry to the normal
12 discipline of the marketplace".

13 "That is an expression used many times. It
14 struck me, and I am asking a question now, "Mr. Maday, it
15 struck me in this connection there is no normal discipline
16 of the marketplace in the sale of", and again that shouldn't
17 be Trilefon, it should be Stelazine -- "by S.K.F. to the
18 retail drug trade. Mr. Maday: No, there is not.".

19 Now, I put it to you also, Mr. Turnbull,
20 that there is a shocking lack of normal discipline of the
21 marketplace when S.K.F. will import Stelazine in bulk at
22 \$1.32 a thousand, and they will expect you -- that is my
23 point -- they will expect you to sell it at \$57.00 for 500
24 or, on my simple arithmetic \$114.00 for a thousand.

25 Do you disagree with me when I put it to
26 you there is a shocking lack of normal discipline of the
27 marketplace in that kind of transaction?

28 MR. TURNBULL: No. I do not think that I
29 could voice my general agreement with you, Mr. Frawley,
30 in that I make no pretence of knowing, although I feel that



1 I know a little bit about these things, but I make no
2 pretence of knowing what is involved in any individual
3 manufacturer's pricing and his costing and this type of
4 thing.

5 I was looking back while you were talking;
6 I was looking back to page 154, where the Director has
7 brought forth the cost of various size packaging. He
8 relates this to finishing supplies, direct labour, manu-
9 facturing overhead, total cost per thousand. I presume
10 that I am correct in adding to that last heading total
11 cost per thousand packages. Now, those figures are quite
12 significant. On that basis I have not had a chance to
13 check these, nor would I want to make any definite state-
14 ment on the situation which you have so excellently brought
15 forth, and I do not know that I could even express agree-
16 ment with Mr. Maday's statement without further study or,
17 first study at least.

18 MR. FRAWLEY: Now, you don't mean to say
19 you are disagreeing with Mr. Maday? Mr. Maday was very
20 frank in saying, no, there is not any normal discipline
21 of the marketplace in the sale of Stelzine by S.K.F.

22 MR. TURNBULL: I don't know.

23 MR. FRAWLEY: Would you like to disagree
24 and go on record as disagreeing?

25 MR. COOK: He said he would not do one or
26 the other.

27 MR. TURNBULL: I don't know. Possibly
28 Mr. Maday has more information than I.

29 MR. FRAWLEY: Nobody needs anymore informa-
30 tion, I put it to you, than just to look at the figures. I



1 want to see, Mr. Turnbull, I am sorry, but I want to see
2 just how timid you are about commenting on this sort of
3 situation.

4 MR. COOK: I don't think the witness has
5 to take that.

6 THE CHAIRMAN: I do not think there could
7 be any inference of timidity here.

8 MR. TURNBULL: You mean should I be timid
9 because Mr. Maday is a member of my council and he is
10 one who votes on my contract this next coming August?

11 MR. FRAWLEY: I didn't know he was a member
12 of your council. I was forgetting about Mr. Maday. I
13 saw you turn back to page 154, and I will put it to you,
14 were you looking for something there that would justify
15 this spread between \$1.32 and \$114.00? Did you find
16 anything that would justify that spread?

17 MR. TURNBULL: I am sorry, as I say, I
18 would want to take a pencil in hand and do a little bit
19 of thinking about a subject that, quite frankly, I would
20 want to explore what all is meant by normal discipline
21 in the industry and this type of thing. These are not
22 common pieces of terminology in my day-to-day activity.

23 MR. FRAWLEY: I will tell you what I mean.
24 I say there is a complete absence of the normal discipline
25 of the marketplace when you simply accept, as apparently
26 you have to accept, the list price that S.K.F. puts on
27 its Stelazine. That is what I say. There is no discipline
28 of the marketplace at all; you simply pay the price or
29 ask the public to pay the price which S.K.F. puts on
30 Stelazine. Isn't that the simple fact?



1 MR. TURNBULL: No.

2 MR. FRAWLEY: Doesn't the fact that you
3 ask me to pay S.K.F.'s price -- if I went into a drug
4 store, wouldn't I pay \$6.25 for 50 tablets of Stelazine?

5 MR. TURNBULL: If the physician had pres-
6 cribed for his diagnosis of your difficulties, Stelazine --

7 MR. FRAWLEY: That is right.

8 MR. TURNBULL: And I was supplying you with
9 Stelazine, undoubtedly I would charge you at the price that
10 is stipulated there, but I would not know what was behind
11 it.

12 MR. FRAWLEY: That is it, and it is because
13 you don't know what is behind itthat I am pursuing this ---

14 MR. TURNBULL: I am speaking of the individual
15 pharmacist who is out in some location very distant from
16 a manufacturing outfit and is not involved in any of these
17 practices or knowledge of pricing practices as they take
18 place at the manufacturers' level, whether that manufacturer
19 be a car manufacturer, paper manufacturer or a drug
20 manufacturer or anything else.

21 MR. FRAWLEY: I am just talking about drugs
22 today. I simply say you simply accept, you blindly accept
23 S.K.F.'s price of \$6.25 for 50 tablets of Stelazine of the
24 2 milligram dosage, and you have nothing to say to him
25 by way of bargaining.

26 You are not able to say to him "Why should
27 I pay you \$56.00 or why should I charge the patient \$6.25
28 for these 50 tablets when you bring them over at \$1.32
29 a thousand?".

30 You don't discuss anything with him at all.



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1 There is no bargaining at all between the two. That is
2 why I say there is an absence of normal discipline of the
3 marketplace. There is no question about it, is there,
4 Mr. Turnbull?

5 MR. TURNBULL: You said it, sir, I did not.

6 MR. FRAWLEY: I said is there any question
7 that there is no bargaining between you and S.K.F. on
8 whether you will pay \$6.25 or \$2.25 or ---

9 MR. TURNBULL: We have stated somewhat
10 similar things right in our presentation, sir, yes. I
11 think we have placed that three or four times in our
12 presentation.

13 MR. FRAWLEY: I was not able to find it.

14 MR. TURNBULL: May I take the time to bring
15 it forth?

16 MR. FRAWLEY: Yes.

17 MR. TURNBULL: You will find it back on
18 pages 110, 111 or 112 or 113, but I think also we can find
19 it under the heading concerning hospitals.

20 MR. FRAWLEY: Mr. Chairman, I am going to
21 see if I can get a glass of water. Mr. Turnbull, are you
22 referring to a page in your brief?

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1 MR. TURNBULL: Page 51, paragraph -- but
2 that is not the specific one.

3 MR. ROSS: Page 49, just under the heading
4 in the middle of the page.

5 MR. TURNBULL: Page 49 I think is our first
6 occasion of stating this. If I may quote: "The retail
7 pharmacist purchases drugs at prices set by the manufacturer
8 without being able to take advantage of contractual agree-
9 ment and other competitive practices which are character-
10 istic of purchases made by institutions." And then page
11 51 makes some reference to this, the effect of institutional
12 purchasing. I believe you will recall our discussions.

13 MR. FRAWLEY: Yes. What that means is when
14 you are buying you are buying in quantities that are far
15 removed from the quantities, for instance, of psychiatric
16 drugs that the Provincial Hospital at Oliver Alberta would
17 be buying. That is what that means, I take it.

18 I am talking about your ability to discuss
19 with Smith, Kline and French the price at which he lists
20 and therefore expects you to charge the patient with the
21 prescription for Stelazine. There is no discussion, there
22 is no machinery for discussion. In fact, you say that
23 you keep strictly away from that kind of discussion.

24 MR. TURNBULL: I believe that a discussion
25 of that nature is the prerogative of Government, not the
26 prerogative of ---

27 MR. FRAWLEY: Mr. Turnbull, I put it a
28 little differently to you. I say that now that the retail
29 pharmacists of Canada know that is what the Green Book
30 says and the S.K.F. is not here uttering one word in denial



1 or contradiction, that now that you know that the retail
2 pharmacists of Canada know that the S.K.F. brings over this
3 product, this Stelazine in bulk form at \$1.32 a thousand
4 that they should from now on refuse to pay the list price
5 which he tells you to put into your price book and charge
6 the public \$6.25 for 50. That is what I put to you.

7 MR. TURNBULL: Let's get one point straight.
8 He doesn't tell us to put it in our price book sir. No,
9 oh no.

10 MR. FRAWLEY: He tells you to charge it
11 to the customer with the prescription.

12 MR. TURNBULL: No, but you made some
13 reference to a company telling us to put it in our price
14 book.

15 MR. FRAWLEY: You make the book yourself
16 as a convenience to your druggists?

17 MR. TURNBULL: As a compilation of existing
18 catalogues, yes.

19 MR. FRAWLEY: Then you charge \$6.00 for it.
20 I hope you make a little money on it. That is neither
21 here nor there. The price that goes on the bottle, or
22 goes on the invoice, or however it is done you are expected
23 to charge \$6.25 for 50 tablets of Stelazine.

24 MR. TURNBULL: No, the Stelazine is \$6.25 that is
25 the suggested list price.

26 MR. FRAWLEY: That is right.

27 MR. TURNBULL: And from which all discounts
28 and that type of thing, trade discounts and that type of
29 thing are placed but nobody has told us anything.

30 MR. FRAWLEY: There is an awful lot of -- an



1 awful lot of elbow room between \$1.32 for one thousand and
2 \$6.25 for 50. There is an awful lot of elbow room for
3 research, for promotion, for direct mail, for samples, for
4 detailmen's salaries or anything you want to mention and I
5 say -- I was challenged in Calgary by Mr. Hume because I
6 used the word "indefensible" but I say that again. I put
7 the same word again because now we are a little different,
8 we have this record closing up. We know what the situation
9 is.

10 THE CHAIRMAN: Mr. Frawley are you presenting
11 argument at this time or are you asking the witness a
12 question?

13 MR. FRAWLEY: I am endeavouring to give the
14 witness the atmosphere in which the question is asked here,
15 and I put something else to you because it is an import,
16 you see. It just happened that Stelazine, and after all
17 as far as you know that happens in a good many cases, there
18 is no basic manufacture in Canada of the drug that is
19 called Stelazine in tablet form is there?

20 MR. TURNBULL: I couldn't say sir.

21 MR. FRAWLEY: And we know from the Director's
22 report again that it is an import so I say that that just
23 aggravates the situation when it is just an import but
24 still, anyway, we will leave it at that. Not only is there
25 no discussion of this thing, not only is there no normal
26 discipline of the marketplace, as I choose to call it, as
27 I say the Edmonton Journal appropriately called it, no,
28 you say there is nothing of the sort. Are you satisfied
29 with the situation or do you think the day may come when
30 you will be allowed to sit down at the bargaining table and



1 find out why you have to pay these prices for these drugs?

2 MR. TURNBULL: You mean me as a secretary and
3 manager of the Canadian Pharmaceutical Association or me
4 as an individual pharmacist practitioner in a community
5 pharmacy?

6 MR. FRAWLEY: You as representing a
7 conglomerate of these retail pharmacists. I am speaking
8 about Mr. Mitchell, Mr. McKeague and all the Mr. Mitchells
9 and Mr. McKeagues in Canada. Why they should not be
10 able to sit down at the bargaining table and find out why
11 they have to pay these prices for these drugs in the light
12 of the cost that has now been put on the record by the
13 Director. Should that not be a happy day we are looking
14 forward to?

15 MR. TURNBULL: I think that such might
16 be looked at with, shall we say, a sideways glance for
17 those who are charged with the administration of the Combines
18 Investigation Act and the Criminal Code of Canada at the
19 present time sir.

20 MR. FRAWLEY: I would say that it deserves
21 a great deal more than a sidelong glance if I might say.

22 MR. TURNBULL: I said at the present time.

23 MR. FRAWLEY: Now you are at some little
24 pains at page 31 and 32 Mr. Turnbull. You are discussing
25 what the manufacturer -- you say you are not doing this
26 as a result of any conference with them, but you are dis-
27 cussing manufacturers' profits. You do not discuss it
28 very much. You say that they are not a subject of delibera-
29 tion on the part of pharmacy practitioners. You just
30 mention it. You mentioned research. You mentioned quality



1 and quality control and then on page 35 you make what I
2 think is a rather extraordinary statement in the second
3 full paragraph, the last sentence. Speaking of promotion:
4 "Individually considered, they may appear expensive, but
5 in relation to an overall budget they, by themselves,
6 probably represent minor expenses the deletion of which
7 would little affect a drug's price."

8 What do you know about the situation that
9 enables you to make that remark, Mr. Turnbull?

10 MR. TURNBULL: I can make a comment but I
11 won't. I don't have very much literature with me. I
12 thought I had sir. However, I think from our reading and
13 our view of the overall industry and the dollars and cents
14 involved in the overall industry that that is not an
15 incorrect conclusion to draw when discussing this matter.

16 MR. FRAWLEY: With every respect Mr.
17 Turnbull, you are just really saying the same thing over
18 again because you put it in there as your feeling that
19 it was not incorrect and now you are saying it is not
20 incorrect and I am simply probing it a little bit and I
21 want to know what information you have on which to say
22 that?

23 MR. TURNBULL: Have you information that
24 disproves it sir?

25 MR. FRAWLEY: What is that sir?

26 MR. TURNBULL: Have you information that
27 disproves our statement?

28 MR. FRAWLEY: No, but you may recall that
29 I asked Mr. Thompson to relate what the segment was for
30 promotion, what the segment was for research, what the



1 segment was for free samples, and he said no, I will not
2 tell you. Now that being so, I say that you don't know
3 anything about it. I don't know anything about it and
4 until the drug manufacturers put it on the table for us
5 to see and the people who sent me here to see you are not
6 able to say that it is minor or major or average or any-
7 thing else about it. I put that to you. Isn't that so?

8 MR. TURNBULL: I do not agree with you.

9 MR. FRAWLEY: You still think without any
10 information you can say it is only a minor part?

11 MR. TURNBULL: I didn't say that I had no
12 information did I?

13 THE CHAIRMAN: I would like to know a little
14 more clearly just what the sentence intends to indicate
15 Mr. Turnbull. I was a little puzzled when you were reading
16 it the other day. You mean that one particular promotional
17 undertaking, while it may cost a specific amount of money
18 is, in relation to the overall budget of the company a
19 fairly small amount? Is that it?

20 MR. TURNBULL: That is correct. We
21 acknowledge Mr. Chairman ---

22 THE CHAIRMAN: Is that a proper comparison
23 to make? You are taking one promotion and relating it
24 to the total promotional expenses, total budget of the
25 company. If you are going to deal with the total budget
26 of the company, should you not take the total promotion?

27 MR. TURNBULL: I believe that you will
28 agree, Mr. Chairman, that what we are driving at here --
29 there has been some criticism of promotion methods by the
30 use of a statuette or something to dramatically bring to a



1 physician's attention the use of a new diuretic preparation
2 or the giving of a volume, particularly bound volume as
3 a gift from a company to the graduating intern, and this
4 type of thing.

5 THE CHAIRMAN: Various types of elaborate
6 and expensive promotion.

7 MR. TURNBULL: That in themselves appear to
8 be extremely elaborate and possibly expensive but I think
9 that there has been many declarations, particularly before
10 the Kefauver Committee relative to the amount of money
11 that has been spent on the so-called frills but it is
12 pointed out that, at the same time, they have had little
13 effect, or if they had not been done they would have had
14 little effect on the overall cost.

15 They might have reduced the cost of a dozen
16 tablets by a fraction of a cent, or a hundred tablets by
17 a fraction of a cent and that is our only reference here.

18 THE CHAIRMAN: You mean that while there
19 might be some expensive promotions in one instance, it is
20 not what you might call a common or usual practice of the
21 company and therefore the one promotional expense or retail
22 promotional undertaking is not very important in the total
23 promotion?

24 MR. TURNBULL: That is correct.

25 THE CHAIRMAN: It may be a good deal of
26 money spent on promoting one product, perhaps a great deal
27 more than in promoting other products?

28 MR. TURNBULL: Yes. It might have a
29 tremendous bearing if all that cost was directly applied
30 to that one particular preparation. Of course, we don't



1 know. It is probably applied to the overall financial
2 picture of the company.

3 THE CHAIRMAN: I suppose none of us knows
4 just how each company operates in that respect.

5 MR. TURNBULL: Well that is just a book-
6 keeping proposition.

7 THE CHAIRMAN: Cost accounting might be
8 concerned, if they had a cost accounting system, might
9 apply it to a certain group of things or particular product.

10 MR. TURNBULL: I believe Mr. Thompson
11 mentioned that he would endeavour to give their figures
12 to the Commission did he not?

13 THE CHAIRMAN: Yes.

14 MR. TURNBULL: Confidential figures to the
15 Commission as opposed to the publicizing of them.

16 MR. FRAWLEY: I am wondering if it ever
17 occurred to you that what you say is a very proper reason
18 for not discussing these matters, cost and expenses that
19 the manufacturer has, is that you don't want to be led
20 into an offence against the Combines Act. Did it ever
21 occur to you that your silence might be interpreted as
22 an accord with the prices which are charged?

23 MR. COOK: I think I must object.

24 MR. TURNBULL: Mr. Cook I would be very
25 pleased to answer this if I may by just referring Mr.
26 Frawley to page 31 and then ask him to retract his state-
27 ment that we have been silent on this. We are "of the
28 opinion that the principle of equal price for equal
29 quantity and equal quality..." et cetera, et cetera has
30 been made known to manufacturers since sometime in 1955.



1 We have not been silent Mr. Frawley but we
2 have not entered into any discussion other than to convey
3 our feelings on this matter to individual manufacturers;
4 no attempt being made to implicate the Association
5 with dealings with another Association.

6 MR. FRAWLEY: Well, when did you start
7 asking for equal prices for equal quantity and equal
8 quality?

9 MR. TURNBULL: The paragraph reads:
10 "Early in 1955".

11 MR. FRAWLEY: Early in 1955 and since 1955
12 bids and tender prices to Government and hospitals and
13 institutions has been going merrily along getting bigger
14 and bigger every year?

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MR. TURNBULL: I don't know.

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MR. FRAWLEY: There is no sign of let-up,
3 is there?

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MR. TURNBULL: Not to my knowledge.

5

MR. FRAWLEY: But you have just contented
6 yourself with repeating year after year, calling their
7 attention - do you call their attention to the fact they
8 are selling to these institutions at low prices that
9 should be increased and the retail price should be
10 brought down? I just wonder how precise your complaints
11 to these manufacturers are with regard to these low prices
12 to Government institutions?

13 MR. TURNBULL: Our complaints in no instance
14 have been related to any bit of precisioness.

15 MR. FRAWLEY: You just discussed in a
16 general way. You feel strongly that there is a too great
17 difference between the price that the mental institution at
18 Oliver, Alberta pays and what the retail druggist has to
19 pay, too big a spread and you call that to their attention?

20 MR. TURNBULL: If the price that the insti-
21 tution that you have named in Alberta is the right price,
22 Mr. Frawley, the other price is incorrect. If the price
23 at the retail level is right the price the institution
24 is paying is incorrect.

25 MR. FRAWLEY: This price, whether you call
26 it correct, it is a price that is bargained out, a price
27 as the result of tender and I don't know a better way to
28 make a price. Let us assume it is a fair price, am
29 I to understand you think the price to the retail pharma-
30 cist is not right?



1 MR. TURNBULL: No individual pharmacist nor
2 pharmacists' organization is in the position of bargaining
3 on behalf of its member pharmacists with regard to prices
4 with any individual or collective group of manufacturers,
5 to my knowledge.

6 MR. FRAWLEY: We have made that very clear.
7 You can't be any clearer than that. You propose to go on
8 calling their attention to the fact there is an undue differ-
9 ence between the price an institution pays and the price
10 which the retail druggist is paying?

11 MR. TURNBULL: As a lawyer, sir, have you
12 any recommendations as to what we should do?

13 MR. FRAWLEY: That is a fair question.

14 THE CHAIRMAN: It may be a fair question,
15 but I don't think this is the place to ask it.

16 MR. COOK: I would be very interested.

17 MR. FRAWLEY: I was just going to say some-
18 thing has got to be done, whether I am the genius that
19 comes up with the answer is the question.

20 THE CHAIRMAN: At the moment you are not
21 giving evidence.

22 MR. TURNBULL: I was wondering why this
23 wasn't the place to ask it, Mr. Chairman.

24 MR. FRAWLEY: Page 41, you are touching on
25 a subject I am not clear about. You say there, starting
26 at the end of the first paragraph: "This Association
27 recognizes this practice" -- that is the fact that dispen-
28 sing pharmacists have accepted the impracticability of
29 subjecting drug products to analysis in the pharmacy --
30 "This Association recognizes this practice and will continue



1 to urge pharmacists to observe the utmost caution before
2 assuming the responsibility for any line of products,
3 where there is not acceptable assurance of full quality
4 control". Now, I wonder what that means? What could a
5 druggist do about an original package containing 100
6 tablets of drug "X"? What could he do to give himself
7 any - to show caution, and I ask you further, what respon-
8 sibility does he assume if it is a sealed bottle of 30
9 tablets of Merck's Decadron? Can you tell me what the
10 pharmacist has to do other than putting a label on the
11 Merck Decadron?

12 MR. TURNBULL: The pharmacist assumes
13 complete responsibility for the drug supplied by him as
14 part of his pharmaceutical service.

15 MR. FRAWLEY: That is a statement about
16 his liability in law, you mean?

17 MR. TURNBULL: Yes.

18 MR. FRAWLEY: That he might be sued if
19 there was something deleterious in a package of Decadron?

20 MR. TURNBULL: Yes.

21 MR. FRAWLEY: What tools do you give him to
22 see that that responsibility is properly discharged?
23 What cautions can he adopt to safeguard that responsibility
24 for this bottle of 30 tablets of Merck's Decadron that
25 comes into the store in a sealed package and is dispensed
in the same sealed package?

27 MR. TURNBULL: It would be very difficult
28 to indicate what tools we give him from the Association's
29 viewpoint. It might be one of those tools that is given
30 him to adjudicate these things. It is the academic degree



1 he earns at University to equip him to utilize his power
2 of vision and smell, utilize his brain, observing the
3 physical attributes of the preparation, possibly to study
4 available literature that might be available to him to
5 determine what in fact he considers to be good and proper
6 relative to, not only a single drug, but relative to the
7 person who indicates that he is the distributor or the
8 manufacturer of the drug. All these factors enter into
9 the whole thing.

10 MR. FRAWLEY: Now, Mr. Turnbull, that is a
11 beautiful generalization.

12 MR. TURNBULL: Thank you, sir.

13 MR. FRAWLEY: I would like you to go back
14 to the question. He receives from his wholesaler, or
15 from Merck, half-a-dozen bottles containing 30 tablets of
16 Decadron. A patient walks in with a prescription for 30
17 tablets of Decadron. Now, the pharmacist would have no
18 objection to giving the sealed package off the shelf after
19 he puts a label on the prescription with his name.

20 MR. TURNBULL: I don't think it is common
21 practice.

22 MR. FRAWLEY: Why shouldn't he get the
23 original bottle?

24 MR. TURNBULL: I don't think it is common
25 practice. I don't know why he shouldn't.

26 MR. FRAWLEY: That is another little side
27 issue. We won't get into taking the original package and
28 putting it in a little box and putting his name on it.
29 Does that pharmacist have enough knowledge to, perhaps, warn
30 against that prescription and say, I don't think I would



1 take this.

2 MR. TURNBULL: He has enough knowledge not
3 to warn against what the doctor ordered for you.

4 MR. FRAWLEY: That is exactly it. He
5 follows the prescription blindly as he is supposed to.
6 I am asking what knowledge has he got of the full quality
7 control that went into the 30 tablets of Merck's Decadron
8 none, none, Mr. Turnbull, surely?

9 THE CHAIRMAN: Mr. Frawley, I don't know if
10 there is any difference between the position of the pharma-
11 cist and the position of some other retailer in the matter
12 of liability. In the Sale of Goods Act there are certain
13 things where the retailer is not, but...

14 MR. FRAWLEY: There may be some instances
15 in the retail drug trade...

16 THE CHAIRMAN: I know of no difference
17 between the position of the pharmacist and other retailers.

18 MR. FRAWLEY: That is true and in that case
19 there is a lessening of the responsibility. Excepting the
20 responsibility that the witness speaks of, I just want to
21 know how any pharmacist can have acceptable assurance of
22 so-called quality control for a bottle of 30 tablets of
23 Merck's Decadron that comes from Montreal to his retail
24 shop.

25 MR. TURNBULL: I don't know how I can
26 answer you. I must be very truthful there. I don't know
27 why I myself came to recognize in my own humble opinion
28 the products of the company you have mentioned are the
29 result of the work of people who I consider to be superior
30 in their field. Their manufacturing facilities I am told



1 and choose to believe, are superior in the field, and
2 they are backed up by an organization that has seen fit
3 to maintain such superiority over many years. All these
4 factors - I don't know how - I have them inside me.
5 I really don't know how, but that is part of the picture,
6 that is a part of the quality control significance that
7 I feel is built into that product.

8 MR. FRAWLEY: How do you know, Mr. Turnbull?
9 How does the retail pharmacist know - I will go further,
10 know anything except that came from Merck? Does he know
11 that the Decadron was actually imported as dexamethasone
12 from Italy or Denmark? He doesn't know whether it was or
13 hasn't.

14 MR. TURNBULL: No, he just knows - you are
15 using company names - he knows that Merck had seen fit to
16 place its name on this particular product and Merck is a
17 company for which he has utmost respect and he feels
18 Merck will not let him down under any circumstances.

19 MR. FRAWLEY: That is correct. If Merck
20 had imported from Italy or Denmark he is sure Merck took
21 satisfactory steps to assure itself that the manufacturer
22 of the basic drug in Italy or Denmark was subject to full
23 quality control.

24 MR. TURNBULL: I wouldn't say that, sir.

25 THE CHAIRMAN: Isn't the position of the
26 pharmacist where you get a prescription for Merck's Deca-
27 dron, isn't your responsibility to see that prescription
28 is filled and what the patient gets is Merck's Decadron
29 of the right strength and right number of tablets with
30 any instructions as to dosage, number of tablets to be



1 taken, whatever it may be - isn't that your responsibility?

2 MR. TURNBULL: Basically.

3 THE CHAIRMAN: The goods are sold on pres-
4 cription.

5 MR. FRAWLEY: That is it, in my respectful
6 submission, he just gives Merck. He doesn't give Frosst's
7 222's. He gives Merck's Decadron. That is where his
8 responsibility ends.

9 THE CHAIRMAN: There could be further liabi-
10 lity, but normally I would think a pharmacist is simply
11 filling the prescription given by a doctor. The circum-
12 stances are not such that the patient is relying on the
13 skill or judgment of the pharmacist, he is not relying on
14 the skill or judgment of the pharmacist to provide some-
15 thing reasonable for the purpose he has in mind, to improve
16 his health or cure certain troubles. The pharmacist has
17 to see the prescription is filled according to the pres-
18 cription given by the doctor.

19 MR. FRAWLEY: I would think so, sir. Mr.
20 Turnbull, will you turn to page 48, the latter part of
21 the second full paragraph. I read you these lines: "It
22 could be said, also, that it reflects..." - the "it" is
23 the situation sometimes referred to as the subsidy of
24 hospital drug costs which is being borne by ambulatory
25 patients - "upon a philosophy which sees fit to bear the
26 full cost of operating an institution for a patient who
27 does not require institutional care rather than guide
28 that patient's rehabilitation by assisting him with the
29 provision of the cost of drugs obtained from the pharma-
30 cist of his own choice". I take it that the kernel of



1 the suggestion is that the agency, the word used in the
2 first line of the paragraph, the agency which may be the
3 Provincial Government or Municipal Government or some
4 agency should assist the ambulatory patient to purchase
5 his drugs from a retail pharmacist rather than keep that
6 patient in the hospital or send him back to hospital after
7 he has been released where his full maintenance would have
8 to be borne by the agency?

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1 MR. FRAWLEY: Have I correctly stated what
2 you said?

3 MR. TURNBULL: I believe that is a correct
4 interpretation, yes.

5 MR. FRAWLEY: Do you when the State assists
6 any ambulatory hospital case to buy his drugs at the
7 retail counter, think they would be using State funds,
8 public funds?

9 MR. TURNBULL: Taxpayers' funds, yes.

10 MR. FRAWLEY: Sometimes called "taxpayers'
11 money"?

12 MR. TURNBULL: Yes.

13 MR. FRAWLEY: I put it to you if you would
14 think that if the patient obtained from the mental hospi-
15 tal from which he was discharged a prescription or a
16 direction, a therapy routine which involved the drug
17 Stelazine, do you think that the agency, the State
18 concerned, would be justified in assisting that patient
19 to buy that drug when that agency knows that it was impor-
20 ted into Canada for \$1.30 a thousand and the State would
21 have to assist the patient in paying \$6.25 for 50.

22 Do you think that the State would then not
23 be justified in saying, "We will have no part of it at
24 all until we know about S.K.F.'s products" and find out
25 why that drug has to be sold at \$6.25?

26 MR. TURNBULL: With reference, as you are
27 making such reference, to a specific drug by a specific
28 brand name, I would have to go along with your supposition,
29 sir. I don't think, however, that the way in which you
30 describe it would alter the basic idea that is being



1 propounded in this particular sentence which you chose
2 to read.

3 MR. FRAWLEY: Yes, well that is a very fair
4 response, if I may say so, Mr. Turnbull. There is nothing
5 really fantastic in selecting Stelazine because if you
6 read the transcript of the Edmonton sittings you will
7 know that the Canadian Mental Health Association appeared
8 before the Commission and told them of a case where a
9 past hospital patient had to have some Stelazine and it
10 had to be bought at retail price and some agency, I don't
11 know, maybe the Community Chest ---

12 MR. TURNBULL: Is there something dirty or
13 nasty about buying at retail prices, sir?

14 MR. FRAWLEY: No, I say there is something
15 in using State funds to drain off State funds on that
16 kind of profit from drugs, that is what I am saying is
17 nasty, I am not pointing any nasty finger at the retailer
18 at all.

19 MR. TURNBULL: Well all right.

20 MR. FRAWLEY: As long as I don't do that
21 then, I am a good boy, Mr. Turnbull.

22 MR. TURNBULL: Well, let us not go that
23 far, sir. I think you and I can get along very well,
24 Mr. Frawley. We both come from the west, sir. You are
25 from a much richer province than I am.

26 MR. FRAWLEY: I heard you talk about Ponoka
27 the other day as though you must have lived there.

28 MR. TURNBULL: No, hardly.

29 MR. FRAWLEY: I want to call your attention
30 to something else now.



1 THE CHAIRMAN: I think we will have a short
2 break, Mr. Frawley, if you are going on to something else.

3 MR. FRAWLEY: That is fine. I am very
4 happy to say I won't be very much longer.

5
6 --- Short Recess

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8 MR.TURNBULL: Mr. Chairman, might we revert
9 back for a second to the discussion which closed just
10 before recess, just to clarify a point?

11 In our discussion concerning the item in
12 question of institutionalizing a person following rehabi-
13 litation, the premise we are attempting to point up here
14 is the possible area of bad therapy coupled with ques-
15 tionsable economics where the discharged patient, because some-
16 one such as a Government agency or the institution did not
17 see fit to assume the figure of \$50 per month during his
18 rehabilitation in private life, this someone was taken
19 back into the institution where his maintenance costs \$210
20 a month.

21 That is what we were commenting on here,
22 not related to the various costs of drugs that might be
23 obtained from private sources, but merely the fact that it
24 is a shame that when a man has been released from an insti-
25 tution, that his rehabilitation in private life cannot be
26 continued and is necessary to allow him to conduct himself
27 with his head held high in private life, even though he
28 knows that someone looking after this expenditure on his
29 behalf while he is becoming rehabilitated.

30 I presume it could be argued that in view of



1 the prices at the retail level and possibly some resis-
2 tance to assuming these costs at the retail level by pay-
3 ments out of monies made available by taxpayers, that
4 this patient being rehabilitated should be asked to go
5 back to the institution to pick up his supplies now and
6 again, in other words force him to face up to the fact
7 that this is the institution from which he was discharged
8 and bring back bad memories of his initial admittance to
9 that institution or possibly it could be argued that
10 maybe some benevolent organization should undertake the
11 supplying of drugs to him, shall we say, through the
12 mails and have the situation such as we had happen in
13 the Department of Veterans' Affairs which has seen fit
14 not to exercise a high degree of caution in its distribu-
15 tion of these drugs.

16 That is our only basis there. It is bad
17 economics to ignore a \$50 bill to take on a bill of \$210
18 a month.

19 THE CHAIRMAN: Is it bad economics neces-
20 sarily for the patient?

21 MR. TURNBULL: I would say so, yes.

22 THE CHAIRMAN: The patient might have to
23 pay \$50 for drugs outside, but if he goes into the hospi-
24 tal in a public ward he pays nothing and gets the drugs
25 free, and from his point of view I can see why he would
26 prefer to stay in the hospital under those circumstances.

27 MR. TURNBULL: I think what we are driving
28 at is, we will never rehabilitate him as long as we keep
29 pulling him back into that institution just because
30 nobody is able to provide the 25% charge for the one



1 element of his rehabilitation, \$50.

2 MR. FRAWLEY: Mr. Turnbull, I would like to
3 put it to you in the setting in which the Canadian Mental
4 Health Association put it in in Edmonton when they told
5 the Commission:

6 "Also, through the White Cross Centre"

7 - that is the Canadian Mental Health Association Centre -

8 "Also, through the White Cross Centre we
9 have information on a middle-aged woman
10 who was discharged from a provincial mental
11 hospital during the summer of 1960 on a
12 maintenance dose of Stelazine. She has
13 been employed as a housekeeper by a working
14 mother with five children. Her total cash
15 remuneration is \$40 a month, the cost of
16 her medication is at least \$15.00 per month.
17 This proved to be an almost insurmountable
18 problem for this woman and the probability
19 is that the stress will ultimately send her
20 back for further hospitalization".

21 I was only putting it to you in that setting.
22 That is the situation as it presented itself to the
23 Canadian Mental Health Association, and you are pointing
24 out that probably there would have to be some assistance
25 in helping that woman to keep her from coming back to
26 the hospital which you suggest is sending her back to
27 the hospital. We would all agree with you in that.

28 But I am now raising a further important
29 question, that to pay out public funds for Stelazine at
30 the rate of \$15 a month to ultimately reach S.K.F. who



1 brings it into Canada at \$1.32 a thousand, that that is
2 a completely new consideration which must enter into the
3 solution of the problem. Do you agree with me, Mr. Turn-
4 bull?

5 MR. TURNBULL: I will agree only to a
6 point. I will agree that it is a shameful situation
7 that there might be forces being exerted upon that woman
8 which would cause the recurrence of her initial unfortu-
9 nate illness, particularly at a time when she had exhibited
10 her ability to rehabilitate herself and to once again take
11 her place in the Canadian community. I would agree also
12 with you on the further point which you make reference to
13 the actual price of medication and price differential in
14 medication, I should say, that I have no knowledge of the
15 many factors which determine the price at which the particu-
16 lar drug namely, Stelazine, is being sold other than to know
17 that the price being asked by the pharmacy practitioner in
18 keeping with his cost is not unreasonable.

19 MR. FRAWLEY: After he has paid for it,
20 then what his mark-up is, is not unreasonable. That is
21 your point?

22 MR. TURNBULL: That is correct.

23 MR. FRAWLEY: I am talking about the price
24 that he has to pay for it in some companies. I think it
25 should be on the record in this place when we are talking
26 about the Commission in Edmonton and the woman that had
27 a medication bill for Stelazine for \$15 a month, when she
28 only was earning \$40 a month cash, I also want to put it
29 on the record at that place that the Mental Institute at
30 Oliver pays \$4 a thousand for Stelazine in 25,000 lots,



1 of course, in large lots.

2 That brings me to what you say at the
3 bottom of page 50 and I am wondering - let me just put it
4 on the record, reading from the last couple of sentences:

5 "Very often, as a result of the above,
6 tendered prices of a manufacturer will
7 be determined on the basis of a variable
8 cost plus a slight excess which may be
9 applied to reducing overhead. He makes
10 a contributory profit in that he receives
11 an amount in excess of his variable cost,
12 but he may not realise a clear profit on
13 such sales".

14 With no offence in the world to you, Mr.
15 Turnbull, how do you know that? Who told you that?

16 MR. TURNBULL: This is what I understand
17 from my discussions with manufacturers, manufacturers
18 who have indicated to me that they know what they are
19 talking about when discussing their own operations, Mr.
20 Frawley. That is how I know about it.

21 MR. FRAWLEY: I don't want to get back into
22 the subject that we spent so much time on earlier this
23 morning and I am not suggesting that you are retracting
24 what you said earlier this morning, but I didn't think
25 you talked prices at all, tender prices or retail pharma-
26 cists' prices or any kind of prices.

27 MR. TURNBULL: We were talking about at the
28 Association level. Let me put it this way, Mr. Frawley.
29 I have received an invitation to address the Canadian
30 Pharmaceutical Manufacturers' Association which holds its



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1 meetings next Monday and Tuesday. I will be addressing
2 that convention for, if I ever get it prepared, 20 to 30
3 minutes, but I will be in their company for approximately
4 a day-and-a-half. I presume that during that day-and-a-
5 half there are many men there whom I have become personally
6 acquainted with, and I presume that I will be discussing
7 with them informally some of these things, yes, just as
8 any businessman discusses the cost of operating his car
9 when he is driving to work, and this type of thing.

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1 It is not a conversation that is involved
2 in actual prices. It is a conversation seeking out
3 knowledge about things that at the moment I do not have
4 too much knowledge on.

5 MR. FRAWLEY: I understand now the setting
6 in which you arrived at the conclusion that you put
7 into your brief at the bottom of page 50. It is the
8 result of friendly discussions with some manufacturers of
9 drugs in which they have been discussing the prices that
10 they get on tender and as those prices are related to
11 their costs?

12 MR. TURNBULL: Yes. In a very generalized
13 informal way, yes.

14 MR. FRAWLEY: Let me give you a couple of
15 examples to test the validity of what -- I won't say of
16 what you say -- of what they tell you. Now, I will put it
17 on the record, and I will put it on the record more
18 formally afterwards, that the Provincial Mental Hospital
19 in Oliver, Alberta, pays \$21.00 for Poulenc's Largactil
20 of 25 milligram dosage.

21 If you will look at page 204 of the green
22 book, you will find some interesting information there.
23 Page 204, you have it?

24 MR. TURNBULL: Yes.

25 MR. FRAWLEY: At page 204 you will find
26 that Poulenc's French subsidiary, Specia, sells Largactil
27 to the retail trade in the same dosage form, 25 milligrams,
28 to the retail trade for 51¢ for 50. My quick arithmetic
29 tells me that is \$10.20 a thousand.

30 Are you going to say the manufacturer



1 Poulenc, when they charge the Provincial Mental Hospital
2 \$21.00 a thousand, buying in 50,000 lots ---

3 MR. TURNBULL: I cannot find those figures,
4 Mr. Frawley, I am sorry. You said something about 51¢
5 for 50.

6 MR. FRAWLEY: Yes. Look at Paris, France.

7 MR. TURNBULL: Yes, I am sorry.

8 MR. FRAWLEY: Specia, Poulenc's subsidiary,
9 price to the druggist, 51¢. Then take a look at what the
10 consumer pays, 77¢. Let us look for a moment at what
11 the druggist pays, for he is a buyer just like my mental
12 hospital in Alberta is a buyer, and I am paying \$21.00 a
13 thousand, and the retail buyer in Paris France could buy
14 it for \$10.20 a thousand, and I am buying in \$50,000 lots.

15 MR. TURNBULL: Let's keep it down to the
16 same 50's. \$21.00 as opposed to 51¢ makes a tremendous
17 difference, particularly when it is not related to the
18 same quantities. You are buying how much on the basis of
19 50 ---

20 MR. FRAWLEY: 51¢ for 50. My arithmetic
21 says \$10.20 for a thousand. Is that right?

22 MR. TURNBULL: Yes.

23 MR. FRAWLEY: All right. That is all I
24 am talking about. So I am telling you to look at the
25 price that my hospital in Alberta pays, \$21.00 a thousand
26 in 50,000 lots, and \$10.20 a thousand for the midinette
27 going into the store in Paris and buying it for \$10.20 a
28 thousand if she thought she needed a thousand.'

29 MR. TURNBULL: I was wondering here, looking
30 at the same chart, Mr. Frawley, why Specia in Paris France



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1 charges \$10.20 per thousand, and in Brussels, Belgium,
2 just a few hundred miles away, it charges \$22.74; in
3 Amsterdam, Holland, the charge is \$22.62.

4 MR. FRAWLEY: Well, it is really very
5 weird, isn't it?

6 MR. TURNBULL: Yes.

7 MR. FRAWLEY: It is certainly weird -- I
8 don't know any better word -- but at the moment I think it
9 is weirdest of all when you compare it to what Poulenc is
10 charging the mental hospital in Alberta, charging them
11 twice in 50,000 lots what their subsidiary in Paris charges
12 over the retail counter, and then you said that they sell
13 to these institutions at just variable plus a small
14 contribution to overhead.

15 THE CHAIRMAN: I think we had better get
16 the record straight. This 51¢ is not the price over the
17 retail counter; it is the price to the retailer.

18 MR. FRAWLEY: Yes, so that the retailer
19 turns around and makes a few cents on it and sells it for
20 77¢. I am sticking to what the retailer pays compared
21 to what my mental hospital in Alberta pays.

22 Those are the figures, and my only question
23 is -- the figures are there for themselves -- I am only
24 saying to you with the greatest respect and deference I
25 do not think you can say therefore in the case of this
26 product that that manufacturer is selling at a variable
27 cost plus a slight excess which may be applied to reducing
28 overhead and he makes a contributory profit but he may
29 not realize a clear profit.

30 MR. TURNBULL: May I direct your attention



1 to page 186, sir, and page 187?

2 MR. FRAWLEY: Of your brief?

3 MR. TURNBULL: Of the green book, paragraph
4 341, halfway through the paragraph: "Poulenc follows the
5 policy of selling at a special low price to government
6 departments and psychiatric hospitals, regardless of the
7 quantity purchased."

8 MR. FRAWLEY: Sure.

9 MR. TURNBULL: There is a company policy
10 statement, and on page 187, the tables listing this out
11 are certainly most illuminating in that they show special
12 price in the 10 milligram range of \$21.00 per thousand
13 as a so-called special price.

14 MR. FRAWLEY: Well, I will tell you it is
15 -- I was going to say it is amusing -- Poulenc follows this
16 policy, but when they are selling to the Provincial Mental
17 Hospital in Oliver, they are selling it at twice what the
18 retail pharmacist in Paris France pays.

19 Can you put those two things together and
20 then translate it into what you have said at the bottom
21 of page 50? Poulenc's may have a policy, but they are
22 charging Oliver double what they should be charging if
23 they are selling it at something -- and I assume they are
24 selling at something more than cost -- at 51¢ in Paris.
25 There is one other question ---

26 TPE CHAIRMAN: Are you going to wait for
27 the answer?

28 MR. FRAWLEY: I am just asking what comment
29 he has to make,

30 MR. TURNBULL: If I may answer you, that is



1 why in our presentation before the Commission we have
2 stated that there is evidence that the retail price of
3 drugs definitely subsidizes the price at which the drugs
4 are sold to the governments, government institutions and
5 hospitals.

6 MR. FRAWLEY: Well, you have told me you don't
7 know anything about these costs. That is only modified
8 by what you have learned in social -- and I attach no
9 opprobrious meaning to that word ---

10 MR. TURNBULL: You don't have to worry
11 about them. It is very fine company.

12 MR. FRAWLEY: You modified the fact you
13 know nothing about costs; you only modified it to the
14 extent you have heard some general statements of the kind
15 you have put into the book, your book, at page 50, but I
16 am only saying to you so far as you know Poulenc may
17 be making a handsome profit selling to our hospital at
18 \$21.00, and then it gives him that much over his variable,
19 and it makes a handsome contribution to overhead? As
20 far as you know, that may be the case?

21 MR. TURNBULL: I said as far as I know he
22 makes a contributary profit in that he receives an amount
23 in excess of his variable costs, but he may not realize
24 a clear profit on such sales.

25 MR. FRAWLEY: I simply put it to you, Mr.
26 Turnbull, this does not apply in the case of Poulenc
27 selling in Paris France and Poulenc selling in quantity
28 to the Oliven mental hospital.

29 MR. COOK: I think it must be made clear,
30 because it has been stressed so long, there is no indication



1 that my learned friend's hospital in Alberta is supplied
2 from the same factory as the factory that supplies the
3 retailer in Paris.

4 THE CHAIRMAN: There are a lot of angles.

5 MR. FRAWLEY: It is Poulenc's Largactil.
6 That is all I know. Is my friend suggesting there are
7 two or three kinds? I say until Poulenc, not my friend
8 Mr. Cook, with great respect, until Mr. Poulenc comes in
9 here and tells us something different, I am entitled to
10 take the green book as the fact. That is all. That is
11 what I propose to do.

12 THE CHAIRMAN: I doubt very much if Mr.
13 Turnbull can express a considered opinion as to whether
14 the company is making a profit on the sale in Paris,
15 France.

16 MR. FRAWLEY: But you see, Mr. Chairman,
17 my position is it is not at all established that these
18 prices to big institutions are those kind -- represent
19 those kind of costs. I am challenging and I am cross-
20 examining him, and I am suggesting what the green book
21 says, that is all. If my friend Mr. Cook has some objection,
22 well, he has stated it.

23 MR. COOK: My objection was not to the
24 question; my objection was to the premise of the question.

25 MR. FRAWLEY: We have heard about Stelazine,
26 and I put it to you S.K.F. is doing very well on Stelazine
27 when they sell it to the Oliver Mental Hospital --
28 according to the green book they bring it into Canada in
29 bulk form at \$1.32 a thousand, and they sell it to my
30 hospital at \$4.00 a thousand, which is a long, long way



1 down lower than what it is sold for over the retail
2 counter.

3 Again, just challenging respectfully your
4 statement at the bottom of page 50, it would look like
5 the difference between \$1.32 at which they import and
6 \$4.00 which they sell in 25,000 lots to the Oliver Mental
7 Hospital gives them a whole lot more than just something
8 ever variable. That would appear to be so?

9 MR. TURNBULL: If it appears that way to
10 you, sir, yes, but not to me.

11 MR. FRAWLEY: If the hospital at Oliver
12 was paying \$4.00 a thousand in 25,000 lots, and if the
13 green book is correct when it says S.K.F. brings that in
14 in bulk form at \$1.32 a thousand, would it not also
15 occur to you that there is more than merely a small con-
16 tribution over variable?

17 MR. TURNBULL: Well, Mr. Frawley, don't
18 misinterpret or attempt to indicate that we are challenging
19 the green book on these excellent figures that they have
20 obtained and presented so well in here. I am merely
21 challenging yours in that you have challenged our state-
22 ment, using the basic figure of \$1.32, and the other
23 figure of \$4.00 or what have you seems to be the same
24 garden path that many people have been led down in that
25 they have not given any consideration to or any acknowledg-
26 ment of some of the factors that might take place to
27 increase that \$1.2 price.

28 We have not, and Mr. MacLeod would correct
29 me, we have not tariffs and duties in that \$1.32 as yet,
30 have we? We have not the freight and handling charges in



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1 there; we do not have any of the charges involved in
2 quality control checks on a quantitative basis, if those
3 are all made in the United States. The quantitative
4 control checks that the company undoubtedly conducts in
5 Canada.

6 We have not taken into account any of the
7 shipping costs presumably out to the Alberta point, or
8 the cost of the salesman to get out to Alberta to convince
9 them that this is the product they should be using, and
10 so many things that I am sure you realize they are all
11 part and parcel of this.

12 MR. FRAWLEY: Oh, sure.

13 MR. TURNBULL: But we do say again that if
14 that \$4.00 price is the correct price, we feel that it
15 should be the only price.

16 MR. FRAWLEY: You know, of course, that the
17 price for S.K.F.'s Selazine in your book, in your price
18 book that you filed yesterday, is \$83.75 for 500.

19 MR. TURNBULL: I don't know, but I will
20 take your word for it.

21 MR. FRAWLEY: That is what it said.

22 MR. TURNBULL: I will take your word for
23 it. I don't know the book too well.

24 MR. FRAWLEY: You say you can't just tie
25 these prices together at all, but at the moment I was
26 only questioning the statement that you made, and if you
27 had not made the statement here I wouldn't be embarking
28 on that kind of an examination at all, but you have gone
29 into this business of justifying the low tender prices
30 by putting it to the Commission that the price is determined



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1 on the basis of variable cost plus a slight increase which
2 may be applied to reducing overhead.

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1 That is just exactly what the railways
2 say when they want to justify a low Agreed Charge. Passing
3 that and looking at this document, I say you don't know
4 anything. I gave you two examples. On the surface at
5 least that proposition which you state at the bottom of
6 page 50 would not appear to stand up because it would
7 appear that there is a very nice profit on the Largactil
8 and equally nice profit on the Stelazine at \$4.00 a
9 thousand.

10 MR. TURNBULL: Mr. Frawley, the statement
11 is made here on the basis that that information we con-
12 sider to be known to us and you challenged our statement
13 on the basis that we don't know. I am afraid that I
14 can only say that your assumptions are only based on
15 presumptions as well sir.

16 MR. FRAWLEY: Well, I want to put on the
17 record five or six of these prices and then ask you the
18 same question. The mental institution in Oliver buys
19 Mowat & Moore, Pro Tran at \$12.10 a thousand;
20 buys Schering's Trilafon at \$58.00 a thousand
21 for the 16 mgm dosage; \$41.20 for the 8
22 mgm dosage;
23 it buys Stelazine at \$4.00 a thousand in the 5 mgm
24 dosage;
25 it buys Smith, Kline & French Parnate at \$37,000.00
26 a thousand;
27 it buys S 1oz Medaril at \$65.80 a thousand;
28 it buys Milcot Warner's Nardil at \$31.00 a
29 thousand; Wyeth's Equanil at \$34.12 a
30 thousand and Geigy's Tefranil at \$49.58 a
 thousand



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1 it buys Squibbs Vesparin at \$41.00 a thousand --

2 I put it to you.

3 THE CHAIRMAN: I think there must be a
4 mistake here, unless my hearing was wrong. I thought
5 you referred to one of them as having an unusual price of
6 \$37,000.00 a thousand.

7 MR. FRAWLEY: That would have been too
8 bad. There is one of Smith, Kline & French's Parnate at
9 \$37.00 a thousand. Not quite that bad.

10 Now you don't know whether or not, not
11 having examined the costs, the variable costs or the
12 overhead costs of those manufacturers, you don't know
13 whether or not they return just a little profit or a
14 handsome profit on the prices I have just read to you?

15 MR. TURNBULL: We have made our statement,
16 sir.

17 MR. FRAWLEY: I put it to you, Mr. Turnbull,
18 that these discrepancies between what the institutions
19 pay and what the retail pharmacist is required to pay
20 should have led you into a demand for something bordering
21 on a bargaining position for the buying of these drugs.

22 MR. TURNBULL: I am afraid that I answered
23 that a little bit earlier by way of asking you a question
24 in your own personal professional capacity and it was
25 pointed out that this is neither the time nor place to
26 obtain that answer.

27 THE CHAIRMAN: You don't answer a question
28 by asking another one.

29 MR. FRAWLEY: Now, Mr. Turnbull, there is
30 something in your brief I think, and if there isn't I will put



1 it to you, some druggists are able to buy with some
2 price advantage. You have told us this morning, Tamblyn's,
3 Rexall, and the members of Drug Trading, do I understand
4 they buy at some disadvantage because either they are
5 large purchasers or because they are in the nature of
6 co-operative and get some indirect benefit that way? Is
7 that it?

8 MR. TURNBULL: I do not recall making
9 reference to this this morning Mr. Frawley. However, I
10 think you used a word incorrectly, that they were at some
11 disadvantage. You mean they were at some advantage?

12 MR. FRAWLEY: Advantage, yes. As I under-
13 stand the purport of what you have been saying there are
14 some advantages to those kinds of buyers that I have
15 mentioned.

16 MR. TURNBULL: I would assume there would
17 be with quantity purchasing and the degree of bigness that
18 is involved enables, shall we say, a pre-use investment
19 by such organizations in larger quantities who possibly
20 take advantage of any particular special offers or what
21 have you.

22 MR. FRAWLEY: This is the interest I have
23 in it. I put to you that the patient going in with a
24 prescription to a drug store in Ottawa that belongs to
25 Drug Trading, that that druggist will consult the list,
26 the list price that you filed as an exhibit, and he will
27 charge the same list price as the druggist that is opera-
28 ting quite independently and has not got the advantage of
29 the Drug Trading buying, using Drug Trading as an example?

30 MR. TURNBULL: There was apparently what we



1 might loosely call a survey conducted in Toronto here by
2 a member of the staff of one of the Toronto newspapers
3 towards the end of last week when nine prescriptions were
4 presented, one each in nine different retail pharmacies in
5 Toronto and I would be willing to wager that all nine of
6 those are members of Drug Trading Company and that the
7 prices varied from 95¢ to \$1.85.

8 MR. FRAWLEY: You are talking about Abbott's
9 Viesterol with something added. I am talking about the
10 three things that I say, in my respectful submission, the
11 green book is concerned with: Bread spectrum antibiotics,
12 ataractics and corticosteroids and I put to you that if
13 I went in with a prescription for, speaking of the cortico-
14 steroids but if I went in with a prescription for 30 of
15 .75 mgm Decadron to a drug store that I would pay \$9.40
16 whether I went into Drug Trading, Tamblyn's or John Brown, who
17 is just an independent drug store and does not belong to
18 any of these large groups.

19 MR. TURNBULL: Possibly we should correct
20 a statement there. You could not go into Drug Trading
21 and buy any of those drugs because Drug Trading is a
22 wholesale house not likely to make drugs available on
23 prescription by a physician or otherwise.

24 MR. FRAWLEY: That was a slip of the tongue.
25 I mean a drug store, a retail pharmacy that belongs to
26 Drug Trading, if that is the way to describe it.

27 MR. TURNBULL: Well, I can't make reference
28 to your corticosteroid preparation but I can, I think you
29 are familiar -- you have used the chloramphenicol which,
30 as you know, is a broad spectrum antibiotic, and if I might



1 make reference to another survey, and we will not comment
2 on the legality or otherwise of it conducted by a news-
3 paper in Toronto and published its results December 12th,
4 1959 and I have already referred to this in our presenta-
5 tion but it reads this, Mr. Frawley ---

6 THE CHAIRMAN: You had better read that
7 on the record, the headline.

8 MR. TURNBULL: "City Drug Prices Showed
9 27% Spread". This is 39 identical prescriptions for
10 chloramphenicol.

11 MR. FRAWLEY: That is the generic name,
12 prescriptions written in their generic name?

13 MR. TURNBULL: It doesn't seem to divulge
14 all that information.

15 MR. FRAWLEY: Oh well, we have to know
16 whether that was Parke Davis' chloromycetin or Gilbert's
17 or Empire's or Starkman's generic chloramphenicol.

18 MR. TURNBULL: That I wouldn't know sir.

19 MR. FRAWLEY: We don't know.

20 THE CHAIRMAN: Perhaps we can get a short
21 answer to the question you have in mind which seems to
22 be this: That if you have a prescription for a brand
23 name drug in the fields described, you go into an indepen-
24 dent drug store or you go into Tamblyn's, you go into one
25 of the member druggists which deals with Drug Trading, can
26 you say that you would or would not pay the same price in
27 those three outlets?

28 MR. TURNBULL: I would say Mr. Chairman
29 that in a certain percentage of those stores you would
30 obtain the prescription at the same price, or a price very



1 close to -- prices very close to one another.

2 Now if you went and took it to five Tamblyn
3 branch stores it would probably be the same price based
4 on the pricing system dictated by Tamblyn headquarters,
5 headquarters staff, of course, and undoubtedly in that
6 immediate area the pharmacist in the immediate area would
7 strike a competitive price, either a little bit below
8 or the same as Tamblyn's.

9 I doubt very much if you would find because
10 they were Drug Trading members or because they bought
11 from other sources for those reasons substantial differences.

12 THE CHAIRMAN: Would the price -- you have
13 indicated in a good many instances you pay the same or
14 very close to the same price -- would the price be
15 approximately at the list price shown in that particular
16 manufacturer's list?

17 MR. TURNBULL: Plus a professional fee,
18 I would say yes. In that immediate neighbourhood, yes.

19 THE CHAIRMAN: Does that mean that the
20 price would be the same in all three types of outlets
21 except for a variation in the professional fee?

22 MR. TURNBULL: Not necessarily.

23 THE CHAIRMAN: I was wondering if you are
24 in a position to tell us.

25 MR. TURNBULL: This is based on experience
26 and conversation again that the suggested list price of
27 the manufacturer serves as a guide to the retailer and
28 the suggestions that have been made relative to the
29 professional fee also serves as a guide to the retailer.
30 Those are two variables, but I don't think you would find



1 very much difference in the prices at which you would buy
2 these various prescriptions, regardless of the outlets
3 provided, of course, that you were remaining in the
4 immediate locality and this type of thing, where competitive
5 factors enter into it.

6 MR. FRAWLEY: Well now, Mr. Turnbull, you
7 have a wide experience in these matters. The list price
8 of Lederle's Aristocort 4 mgm dosage is \$12.11 for 30 in
9 your book. Now, is there any serious question in your
10 mind that if you went around -- which, of course, let me
11 say right now is not the practical way for your day to
12 day procedure, but if for some reason you wanted to go
13 around and price that Aristocort, that bottle of 30 tablets
14 of Aristocort that you would find any wide variation from
15 \$12.11 except any such variation that might come from a
16 desire to get away from the uneven amount, \$12.00 or
17 \$12.25 which I would regard as a substantial adherence to
18 the list.

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1 MR. FRAWLEY: Other than that you don't mean
2 by flashing a Toronto newspaper for 27% variation - you
3 don't mean to leave with the Commission the impression
4 that if a person walks around Toronto shopping, we will
5 say, for 30 tablets of Lederle's Aristocort, he would
6 find 27% variation in the price of that branded triam-
7 cinolone?

8 MR. TURNBULL: Possibly I could answer by
9 making reference to this one specific case, specific
10 information on December 15th. The other, or one of the
11 other Toronto papers, namely the Daily Star...

12 MR. FRAWLEY: What year?

13 MR. TURNBULL: December 15th, 1959, I am
14 sorry. It is referred to in our presentation. That was
15 the one that had in red headlines, it told the great public
16 how you can be bilked by buying drugs. It says here and
17 I quote:

18 "All four of the antibiotic preparations were
19 filled with the Parke-Davis trade name
20 Chlormycetin. None of the stores tried
21 was able to supply the drug under its
22 chemical name chloramphenicol".

23 I think you understand that is nonsense
24 because Chlormycetin is chloramphenicol. To continue my
25 quote:

26 "The following price range was noted for
27 identical products: Store C 43.1¢ per
28 capsule; Store E 58.4¢ per capsule; Store
29 D 60¢ per capsule; Store B 69.5¢ per
30 capsule."



1 That is the only information I have. I
2 presume the newspaper...

3 MR. FRAWLEY: With respect you have selected
4 a drug which is available for purchase either by generic
5 name or by its brand name. I am giving you an example
6 of a well-insulated brand name.

7 MR. TURNBULL: Just a minute now, it says
8 right here all four of the antibiotic prescriptions were
9 filled with the Parke-Davis trade name product, Chloro-
10 mycetin.

11 MR. FRAWLEY: All I am saying, Mr. Turnbull
12 is the Toronto paper selected an antibiotic for which
13 there is a generic equivalent on the market in Toronto.
14 That is true, isn't it?

15 MR. TURNBULL: I don't know.

16 THE CHAIRMAN: Without trade name?

17 MR. FRAWLEY: There is a generic equivalent
18 on the market for Parke-Davis' Chlormycetin, namely
19 chloramphenicol.

20 MR. TURNBULL: I am not prepared to say it
21 is equivalent. There is a generic name product on the
22 market.

23 MR. FRAWLEY: I don't want you to make a
24 commitment that is distasteful to you. There is considered
25 by some people to be a generic equivalent of Parke-Davis'
26 Chlormycetin and that is called chloramphenicol. I
27 selected a totally different situation, as I said, a
28 well-insulated brand name; namely Lederle's Aristocort
29 for which, so far as I know, there is no generic equivalent
30 on the market, namely there is no product, as I understand



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1 it, sold in Canada under the generic name, triamcinolone.
2 I am only putting it to you a person who wanted to go
3 shopping for 30 tablets of Lederle's Aristocort - I put
4 it to you making allowance for the fact that the list
5 price is \$12.11, I put it to you that a person would
6 find if he was paying the same or substantially the same
7 price wherever he took his prescription.

8 MR. TURNBULL: That I don't know, sir.
9 May I ask - this is not a question directed at you. We
10 could possibly get an example here. You indicated you
11 took Decadron?

12 MR. FRAWLEY: I myself?

13 MR. TURNBULL: Yes.

14 MR. FRAWLEY: I have had it prescribed.

15 MR. TURNBULL: May I ask you what you paid
16 per dozen?

17 MR. FRAWLEY: I read from here \$9.40 for
18 30.

19 MR. TURNBULL: You don't recall what you
20 paid for the prescription?

21 MR. FRAWLEY: I don't recall. I would say
22 in that neighbourhood.

23 MR. TURNBULL: I have taken very few drugs
24 in my life, myself, but it happened this time last year
25 I was forced to take Decadron. I had two prescriptions
26 and I thought maybe we could establish a basis of compari-
27 son, you being in Ottawa and me being in Toronto.

28 MR. FRAWLEY: I think we both paid \$9.40.

29 MR. TURNBULL: I had it at the dozen level,
30 at least my prescriptions were at the dozen level so I



1 can't go by that.

2 MR. FRAWLEY: How about Aristocort?

3 MR. TURNBULL: I couldn't tell you that.

4 I only assume the generalization made previous and the
5 figures brought out by the Toronto Star survey in which
6 it claimed that the public is being bilked pertain to
7 Aristocort as well.

8 MR. FRAWLEY: Thank you.

9 THE CHAIRMAN: You have completed all your
10 questioning?

11 MR. MACLEOD: There is one question, with
12 the permission of the Commission, I would like to ask.
13 I neglected to ask this: do you know of the very exceptional
14 situation arising in respect to certain patent or proprietary
15 medicines where the wholesaler will actually get his
16 stock from a retailer for a retailer to take advantage
17 of some special deal?

18 MR. TURNBULL: Could you quote an instance,
19 Mr. MacLeod, so you could refresh my memory? It has been
20 a little while since I have had close contact with whole-
21 sale in the patent or proprietary medicine field. Would
22 this be an instance where it is not the company's policy
23 to sell through a wholesaler so the wholesaler takes the
24 other recourse to obtain supplies to meet certain demands?

25 MR. MACLEOD: I was wondering if you could
26 say that was the situation with respect to certain patent
27 medicines; one, well-known headache remedy, I have in
28 mind.

29 MR. TURNBULL: It seems to me such does take
30 place that there are deals of that nature, but for the life



1 of me, I can't think of the one you have in mind at the
2 moment, nor can I think of a specific instance about which
3 I have heard. It wouldn't be an unusual thing if a
4 company had a policy of that nature, distributing only
5 direct. Whether it is considered as proper or not is
6 beside the point here.

7 MR. MACLEOD: You had certain discussions
8 with Mr. Frawley about variations of the policies of
9 manufacturers in selling to the retailer and wholesaler.
10 I was wondering if you knew of the very unusual situation
11 of the wholesaler having to buy from the retailer in order
12 he can sell it to another retailer.

13 MR. TURNBULL: In some cases there are deals,
14 I believe, that are made on direct sales and I presume -
15 in fact, I have heard of some instances, and such deals
16 are not available to the wholesalers.

17 MR. MACLEOD: I think perhaps that is as far
18 as we can take it on the basis of your knowledge. That
19 was all.

20 MR. TURNBULL: I would say, with regard to
21 wholesale and direct sale discount - have you, Mr. MacLeod,
22 these two catalogues - I believe you have the Squibb and
23 Lederle.

24 MR. MACLEOD: No, two Lederle.

25 MR. TURNBULL: In the opening pages it will
26 outline Lederle's distribution policy if my memory serves
27 me right. It is few years since I have seen it.
28 Lederle, Squibb and a few others were involved in a
29 distribution policy change, I think it was about a year
30 ago, whereby the wholesaler is not buying to any advantage



1 or very little advantage through the retailer on direct basis
2 and secondly the retailer who buys such products from the
3 wholesaler because of his size or other conditions, he
4 receives a much lower percentage discount than he would
5 under the ordinary circumstances.

6 MR. MACLEOD: These catalogues, as well as
7 some others, are available to the Commission. I might
8 also say the tables set out in the Green Book are extracts
9 from a much larger compilation of prices made under the
10 Director's supervision and, of course, the original work-
11 sheets will be available to the Commission so that the
12 Commission will have full information on the exact
13 relationship of prices, retail prices, wholesale prices,
14 prices to hospitals, etc.

15 MR. CARIGNAN: Just one more question.
16 Would it not be appropriate for your Association to put a
17 check on the kind of advertising which it is admitted on page
18 103 appears in the Journal and is primarily emphasizing the
19 profit advantages?

20 MR. TURNBULL: I don't have separate copies
21 of the Journal with me, but I would be very pleased, sir,
22 to make available to you the Journal that Mr. Antoft made
23 specific reference to, and even a cursory review of Mr.
24 Antoft's references to costs and that type of thing, even
25 a cursory review will indicate that he is quoting out of
26 context. I didn't want to say this, but I am afraid it is
27 correct. Now, relative to our policy concerning the
28 acceptance of advertising in the Journal we attempt to
29 temper the advertising message where, in our humble
30 opinion, it is not quite right, shall we say, but we don't



1 force our will upon the advertiser. If it is necessary
2 to force our will upon him we are in the position we don't
3 accept the ad and therefore the ad does not appear.

4 MR. CARIGNAN: In many advertisements in
5 the issue that has been filed with the Commission, the rate
6 of profit is indicated as the main factor, for instance,
7 Sell this kind of pill, the rate of profit is so much .

8 MR. TURNBULL: That is pertaining to items
9 that are available for sale without prescription.

10 MR. CARIGNAN: Probably you are right. I
11 am not too sure, but I think so.

12 MR. TURNBULL: Do you have the same copy I
13 have? Yes, I have that one. Mr. Carignan, shall we look
14 at it? We could go through each one. Page 5, you see,
15 products are available for sale over-the-counter. This
16 is all deal prices in here containing rates of profit.

17 MR. CARIGNAN: Is that the issue filed
18 yesterday?

19 MR. MACLEOD: It is one of the issues.

20 MR. TURNBULL: I don't think I filed an
21 issue yesterday.

22 MR. ROSS: Yes, last September's.

23 MR. TURNBULL: I have one. There was one of
24 those filed yesterday.

25 MR. CARIGNAN: Here, for instance, in the
26 issue of September, 1961, page 83, the kind of drugs are
27 advertised - I see "Cash in on these profitable drugs".
28 My question is, I wonder - then at the bottom "Order now,
29 quick profits, fast turnover".

30 MR. TURNBULL: I have a basic knowledge of



1 these two particular products. One is a toothache remedy,
2 the other dental poultice. It states right on there
3 number so-and-so under the Proprietary or Patent Medicines
4 Act and it contains 3% benzocaine and other ingredients.
5 These are available any place, anywhere at any time
6 without any supervision whatsoever. It is strictly a
7 merchandising proposition.

8 MR. CARIGNAN: In that the pharmacist is
9 expected to guide the customer - these products are
10 bought without prescription and a pharmacist is expected
11 to guide the customer. Now, he should advise the customer
12 to buy one kind of product because it is best, not because
13 it is more profitable for him to sell that kind and not
14 another kind.

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L/JW/hm

1 MR. TURNBULL: I don't think that is what
2 the ad is saying, sir. The ad is suggesting that now --
3 and I will point out some of the reasoning here -- we are
4 coming to the time of the year when the winter winds are
5 blowing across the prairies and freezing is a real problem
6 in shipping and so at this time of year with this type
7 of product you will often find special deal prices
8 attempting to get retailers of one type or another to lay
9 in a stock ahead of this dangerous freezing period. By
10 doing so they woo their customers by saying: "Here, we
11 will give you a special deal if you will keep this stock
12 on hand a little bit longer". It might indicate that the
13 profit goes up a little bit, but that will be absorbed
14 in the storage facilities and that sort of thing.

15 THE CHAIRMAN: That is not just what this
16 says. It says, "Order now. Quick profits. Fast turnover".
17 It doesn't indicate they will have to keep it on the
18 shelf a little longer.

19 MR. TURNBULL: Yes, that is the advertising
20 idea, of course, quick profits.

21 I don't believe that you will find that
22 type of measure concerning what we choose to call
23 "pharmaceuticals", with certain exceptions, of course.
24 In that same issue, page 79, in which Merck is indicating
25 how good Crystalline Vitamin B is, you will find the
26 commercialized type of advertising in the inserts just
27 ahead of the survey as well, a combination deal with a
28 chest rub proposition and a fixture manufacturer, but it
29 is related to modernization by fixtures as well as selling,
30 and the pharmaceutical advertising again on page 25.



1 MR. CARIGNAN: Here no price appears on
2 this one, and it is quite all right, but the others I see
3 they tell what will be the profit for the druggist, or
4 at least they indicate that the profit may be so much.

5 MR. TURNBULL: Yes.

6 MR. CARIGNAN: And the druggist surely is
7 able to calculate himself what profit he will make. I
8 think that such appeals should not be made to price to
9 a profession, especially in the Journal of the Association.

10 MR. TURNBULL: Of course we have to con-
11 sider that these profit appeals and that type of thing,
12 sir, are related to the business side of the pharmacist's
13 business establishment. They are not necessarily related
14 to the items that he will use in his dispensary to meet
15 the prescription demands. These pertain to, shall we say,
16 front store, or front counter selling items. I would be
17 the very, very first to agree with you, and this is not
18 a new story. We have debated this very often in our own
19 Committees relative to the desirability of certain pieces
20 of advertising and that type of thing.

21 Regrettably associations such as our and
22 such as I imagine just any other association has to face
23 the cold hard fact that we have to have a certain number
24 of dollars to assist us in the publication of our magazine.
25 At the same time we realize that this price information
26 as contained in advertisement concerning profits and
27 what not, does have value to the retailer. At the same
28 time it enables us to publish a magazine which we hope
29 will advance the retailer's work in his community.

30 There is no question that we whole-heartedly



1 agree with you that it would be most desirable to never
2 mention these nasty terms of "plus 10% bonus profit", and
3 this type of thing, but it enters into the field of
4 commerce. We don't really think that a discussion in an
5 advertisement of that type of profit and profit structures,
6 provided it is not blatantly thrown about, is to be
7 discouraged in the field of commerce today.

8 I am sorry I can't possibly give you a more
9 specifying answer to what you are seeking, but there are
10 so many things involved in the acceptability and the accep-
11 tance of advertising messages.

12 THE CHAIRMAN: That would conclude the
13 examination unless you have some questions, Mr. Cook.

14 MR. COOK: I only have one question, if I
15 may, sir. I have not that copy of the Journal in front
16 of me, but the advertisement to which you are referring
17 and the advertisement which had this financial connotation,
18 are these articles that I can buy in the cigar store or
19 Loblaws?

20 MR. TURNBULL: Some of them are and some
21 of them are not. Those that came into this initial dis-
22 cussion are, yes.

23 THE CHAIRMAN: That would seem to conclude
24 the examination of Mr. Turnbull and the presentation on
25 behalf of the Pharmaceutical Association. Once again I
26 would like to say we have greatly appreciated the
27 extreme care in which you have prepared your brief and
28 the very frank way in which you have discussed matters
29 during the course of the hearing.

30 MR. TURNBULL: Thank you sir..



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TORONTO, ONTARIO

Turnbull

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1 THE CHAIRMAN: I believe we have a witness
2 coming this afternoon.

3 MR. MacLEOD: Mr. Gilbert advised me he
4 would be here this afternoon.

5 THE CHAIRMAN: Then, would 2.15 be too soon?
6 It is a little less than an hour and a half. We will
7 adjourn till 2.15 this afternoon.

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9 ---Luncheon adjournment.

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EMT/dpw

1 --- On resuming at 2.15 p.m.

2 THE CHAIRMAN: Mr. Gilbert, I believe you
3 have a brief?

4 MR. GILBERT: That is right. It will be a
5 very short statement.

6 THE CHAIRMAN: I think perhaps you might
7 read it, and if you have any comments to make as you go
8 along.

9 MR. GILBERT: I wish to thank the Chairman
10 and the members of the Investigational Committee for
11 presenting my company the opportunity to answer any
12 questions that may have arisen, regarding our policies,
13 our pricing system, our quality controls, our views on
14 patents, and on the possible savings that could accrue,
15 to hospitals, to the sick and to the nation of Canada.

16 My background is such, that I have had
17 contact experience with almost every phase of the drug
18 industry. Therefore, I believe myself in a practical
19 way, to be in a knowledgeable position to discuss the
20 basic conditions and the human motivations which are the
21 cause of this investigation. I hope that any testimony
22 I give will be helpful in arriving at a proper solution.

23 There seems to be a mystery surrounding the
24 issue of drug patents both from legal and moral aspects.
25 Drug patents seem to have an aura similar to that placed
26 around the subject of medicine. While I have never
27 studied law, I feel that I can discuss drug patent law in
28 an edifying manner. This may be important because I
29 believe patents to be the cornerstone, which is the key to
30 the controversy.



1 My thesis is simple:

- 2 1. Today in Canada quality controlled
3 drugs are available at prices as low as
4 anywhere else in the world.
- 5 2. This availability has not, to any
6 degree as yet reached either the hospitals
7 or the public.
- 8 3. The drug distribution system is so
9 constituted, that there exists an effective
10 barrier to the marketing of the low cost
11 drug.
- 12 4. If this barrier exists, there must be
13 a combination in restraint of trade which
14 prevents the orderly functioning of basic
15 economic principles.
- 16 5. The high cost of drugs in Canada serves
17 to enrich the foreign ownership which
18 controls approximately 90% of the Canadian
19 drug industry, and is effectively preventing
20 Canada from building its own industry.
- 21 6. Our company, while importing basic drugs
22 from abroad, still finds that it can
23 effectively compete in selling finished
24 and packaged drugs to foreign markets.
- 25 In eliciting the whys and wherefores of the
26 six points mentioned, the Committee I hope, will find the
27 solution.

28 In closing, I wish to say, that I feel that
29 I owe Mr. Turnbull and Mr. Hume an opportunity to question
30 me on the brief I presented to the Ontario Select



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Gilbert

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1 Committee on Drugs about a year ago (I will be pleased to
2 enter my copy as an exhibit). They expressed serious
3 concern about some of my statements. I have high regard
4 for the abilities and knowledge of Mr. Turnbull and Mr.
5 Hume, and I hope that I will learn much from their ques-
6 tions and criticism.

7 I beg the indulgence of the Committee if
8 some of my statements are approximate, because, until
9 yesterday I had no intention of appearing before the
10 Committee and therefore had little opportunity to raise
11 supporting documentation.

12 Thank you.

13 THE CHAIRMAN: Do you wish to make any
14 comments before the questioning starts?

15 MR. GILBERT: I think this gives my stand.
16 I want anybody to feel free to ask any questions of me.
17 I don't mind feeling embarrassed or anything.

18 THE CHAIRMAN: The first question that
19 occurs to me is under your first point at the top of page
20 2. Where you say in Canada quality controlled drugs are
21 available at prices as low as anywhere else in the world.
22 Is that not taking in a lot of territory? I am thinking,
23 for instance, of France, where I understand they have a
24 special situation.

25 MR. GILBERT: I think you will find if
26 proper marketing is done, proper purchasing practices
27 are effected, there is a normal mark-up basis which can
28 ultimately be achieved which will then drop it to the
29 manufacturer and still make my statement hold true.
30 That would include France or anybody else.



1 MR. WHITELEY: What do you mean by
2 "available"?

3 MR. GILBERT: They are available, period.
4 They are here now.

5 MR. WHITELEY: Let us take a foreign
6 country and say the price is X.

7 MR. GILBERT: Yes.

8 MR. WHITELEY: If that item is imported to
9 Canada, wouldn't you have to pay import duty and Canadian
10 sales tax to make that price X plus?

11 MR. GILBERT: I think we would have to go
12 into a specific illustration of a going price in the
13 country. I know that our ability to buy drugs is such
14 that we can even compete competitively with world market
15 prices while importing the material, and have done this
16 on occasions by getting special prices.

17 MR. WHITELEY: You mean import the drug and
18 then re-export it?

19 MR. GILBERT: That is right, in competition
20 with world prices. It takes a little knowledge and
21 ability and knowing where to go and how to handle it, but
22 it can be done.

23 MR. WHITELEY: Perhaps you are exporting
24 to some country that has perhaps a British Preference?

25 MR. GILBERT: No, I am not discussing that
26 at all.

27 THE CHAIRMAN: Do you wish to ask some
28 questions, Mr. MacLeod?

29 MR. MACLEOD: Well, Mr. Gilbert, you speak
30 of your background as such, and you have had experience



1 in almost every phase of the drug industry. Perhaps for
2 the record you would give the Commission your qualifica-
3 tions and your experience in the drug field.

4 MR. GILBERT: With your kind permission,
5 I would like to do it on the basis of reading my presen-
6 tation to the Select Committee of Ontario, the Ontario
7 Select Committee on Drug Prices.

8 THE CHAIRMAN: Are you going to file a
9 copy of that with us as an exhibit?

10 MR. GILBERT: Yes, I will be glad to do that.
11 If I may, I will read that.

12 MR. MACLEOD: You are filing a copy which
13 contains both particulars of your experience and qualifi-
14 cations?

15 MR. GILBERT: That is right.

16 MR. MACLEOD: Then I think perhaps that
17 will cover it, will it not, sir?

18 MR. GILBERT: It would only take about two
19 minutes to read it if you want it read in.

20 THE CHAIRMAN: It is a fairly big volume,
21 perhaps you had better read that part in.

22 MR. FRAWLEY: The Ontario Select Committee
23 proceedings are available, and I suppose available to me
24 at a price, but I have not seen it so I would ask Mr.
25 Gilbert to read it.

26 THE CHAIRMAN: I think it is only a page
27 or two. You had better read it in.

28 MR. GILBERT: Age 54, married, two daughters.
29 In 1926, graduated from Columbia College of Pharmacy,
30 degree of Ph.G. 1926, two years ---



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Gilbert

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1 THE CHAIRMAN: That is Columbia, New York?

2 MR. GILBERT: Yes, Columbia College. 1926,

3 two years and two summers with G.W. Carwick Co., Newark,

4 N.J. - Laboratory Control and Research in endocrine

5 products. 1931, B.S. in Ch. Engineering, Cooper Union

6 Institute of Technology. 1932, Research Chemist in

7 privately endowed Cancer Research. 1933, Assistant Supervisor

8 pharmaceutical Department, National Aniline and

9 Chemical Company, Buffalo, N.Y. Synthesized about 200

10 Organic and Biological stains. 1936, started National

11 Synthetics Inc. - now, Bell-Craig Inc., New York City -

12 manufacture of x-ray diagnostic media. 1945, Patent

13 Action: Schering versus Gilbert decided. 1946, started

14 drug company in Toronto - producing a variety of drug

15 specialties - no longer associated with this company. 1948,

16 started Gilbert Surgical Supply Company Limited for the

17 sale of Hospital Supplies. 1943, started Jules R. Gilbert Ltd.

18 as drug jobber. 1957, Gilbert & Company embarked on

19 Generic Drug Program.

20 THE CHAIRMAN: Was it 1943 or 1953 when

21 you started Jules R. Gilbert?

22 MR. GILBERT: 1953.

23 THE CHAIRMAN: I think you said 1943.

24 MR. GILBERT: Gilbert Surgical Supply Co.

25 Ltd. does business as Gilbert & Company engaged mainly in

26 sales to doctors, hospitals and drug stores. We currently

27 occupy a 20,000 ft. single story building devoted to 4,000

28 ft. office space, 9,000 ft. warehouse and 7,000 ft. of

29 packaging manufacturing and laboratory area. The manufac-

30 turing area has excellent equipment for manufacture of



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Gilbert

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1 tablets, capsules, powders and liquids. The production
2 efforts are almost completely dedicated to our own pro-
3 ducts. We do not seek custom manufacturing. The Labora-
4 tory is used to perform in process controls. All raw
5 materials and finished products are tested by an indepen-
6 dent Laboratory on a retainer basis.

7 The companies are faced with ten patent
8 suits entered by Parke-Davis, Poulenc, Pfizer, Schering
9 Horner, Haechst, American Cyanamid, G.D. Searle and Ciba.
10 The Frosst action was voluntarily withdrawn. We are
11 countersuing two companies - Horner and Frosst under the
12 Ontario Monopolies Act.

13 I might add at this point that we are also
14 suing the Canadian Pharmaceutical Association and Mr.
15 Conder for libel.

16 Further expansion plans are in progress to
17 provide a model control and research laboratory and a
18 sterile area for packaging antibiotics.---

19 THE CHAIRMAN: You said you were suing the
20 Canadian Pharmaceutical Association?

21 MR. GILBERT: I mean the Manufacturing Asso-
22 ciation. That is an error here.

23 The Pharmaceutical plant is staffed by
24 capable experienced personnel.

25 I would like to suggest that - well, this
26 is non-pertinent here.

27 THE CHAIRMAN: That will be an exhibit.

28 MR. GILBERT: This is a brief outline.

29 THE CHAIRMAN: It is an outline of your
30 activities?



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Gilbert

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1 MR. GILBERT: Yes.

2 MR. MACLEOD: How many products, that is,
3 in the pharmaceutical line, does your company sell?

4 MR. GILBERT: Well, in our catalogue, we
5 have about 300 products listed. I have not bothered to
6 count them. They vary all the time.

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1 MR. MacLEOD: Now that will be 300 finished
2 dosage forms?

3 MR. GILBERT: That is right.

4 MR. MacLEOD: How many of those dosage
5 forms would be prepared by your company and how many
6 would they obtain as finished dosage forms from some other
7 source?

8 MR. GILBERT: I would say that about 70%
9 are our own preparations.

10 MR. MacLEOD: Do you make any basic drugs
11 at all? That is, raw materials?

12 MR. GILBERT: No.

13 MR. MacLEOD: Those are all purchased?

14 MR. GILBERT: That is right.

15 MR. MacLEOD: Now perhaps we ought to get
16 your pricing cleared up Mr. Gilbert. You publish a
17 volume called "Gilbert Surgical News"?

18 MR. GILBERT: Right.

19 MR. MacLEOD: And the one I am looking at
20 is already marked as an exhibit T-3. In the centre pages
21 of that you set out certain prices of drugs, is that
22 correct?

23 MR. GILBERT: Right.

24 MR. MacLEOD: And in one column you have
25 the brand name at professional prices?

26 MR. GILBERT: Correct.

27 MR. MacLEOD: Are those the prices at
28 which you would sell those products if the customer ordered
29 them from you?

30 MR. GILBERT: This would be the doctor price.



1 The price to the doctor.

2 MR. MacLEOD: That is the price at which
3 you would sell these drugs to the doctor?

4 MR. GILBERT: Right.

5 THE CHAIRMAN: What page are you reading
6 from?

7 MR. MacLEOD: Page 25. Do you know if
8 doctors or retailers or other trade customers may buy at
9 different prices from the makers of these products?

10 MR. GILBERT: I would suspect that some
11 get better advantages than others depending on the volume
12 of their purchase and probably their particular situation
13 in the field.

14 MR. MacLEOD: Is it a fact that these brand
15 name -- the prices of the brand name drugs which you set
16 out are the list prices less 25%?

17 MR. GILBERT: That is what is generally
18 meant by a professional price.

19 MR. MacLEOD: Is it that?

20 MR. GILBERT: That is our construction of
21 this.

22 MR. MacLEOD: Going to the other column:
23 Proper name drugs, proper prices, properly prepared, you
24 set out certain prices there and these you say are the
25 price to the doctor?

26 MR. GILBERT: That is right. These are net
27 prices.

28 MR. MacLEOD: These are net prices. What
29 relationship would these prices bear to prices which you
30 charge retailers?



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Gilbert

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1 MR. GILBERT: When you say retailers, you
2 mean a drug store?

3 MR. MacLEOD: Drug store.

4 MR. GILBERT: The drug store would get 20%
5 discount from this price.

6 MR. MacLEOD: What would a wholesaler get?

7 MR. GILBERT: If we had the co-operation of
8 a wholesaler they would get 20% and 1/6th.

9 MR. MacLEOD: Is that the same 20 that the
10 retailer gets?

11 MR. GILBERT: That is right.

12 MR. MacLEOD: That is, the 20 would bring
13 it down to the retailer's level and then they would get
14 1/6, 16-2/3% above that?

15 MR. GILBERT: That is right.

16 THE CHAIRMAN: Off what is left?

17 MR. MacLEOD: Off what is left.

18 MR. GILBERT: In other words, the discount
19 would be 20 and 16-2/3.

20 MR. MacLEOD: There is just one point, you
21 mentioned a moment ago that if you could induce whole-
22 salers to stock your products or something. Do you have
23 difficulty in getting wholesalers to stock your products?

24 MR. GILBERT: Yes.

25 MR. MacLEOD: To your knowledge are your
26 products stocked by National Drug and Chemical Company?

27 MR. GILBERT: No.

28 THE CHAIRMAN: You mean they are not stocked?

29 MR. GILBERT: No.

30 MR. MacLEOD: By the Independent Drug Trading



1 or ---

2 MR. GILBERT: Not stocked there either.

3 MR. MacLEOD: Do you know the name of the
4 wholesale branch of the Cunningham organization on the
5 West coast?

6 MR. GILBERT: Would that be Western
7 Wholesale?

8 MR. MacLEOD: I am not sure of the name.

9 MR. GILBERT: I think it is something like
10 that.

11 MR. MacLEOD: In any event, does the whole-
12 sale end of the Cunningham drug chain stock your products?

13 MR. GILBERT: No.

14 MR. MacLEOD: Are there any large whole-
15 salers in Canada who do stock your products?

16 MR. GILBERT: No. I might add that
17 presentations have been made to some of them.

18 MR. MacLEOD: With what success?

19 MR. GILBERT: My previous testimony answered
20 that.

21 THE CHAIRMAN: You said no large wholesalers
22 stock your products?

23 MR. GILBERT: Or small ones.

24 THE CHAIRMAN: Or small ones? You mean no
25 wholesalers stock your products?

26 MR. GILBERT: No sir.

27 MR. MacLEOD: In a letter of May 29th, 1961
28 to the Commission in answer to a request for certain
29 information you said: "We have not issued Surgical News
30 since November 1960 but there is one on the press currently"



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1 and could be made available in about ten days. We are
2 currently planning to issue a new drug catalogue in which
3 we propose to set up a new discount schedule of 40% to
4 druggists and 50% to hospitals and wholesalers." Have
5 you put that into effect yet Mr. Gilbert?

6 MR. GILBERT: We are still working on that.

7 MR. MacLEOD: And is this catalogue of
8 Jules R. Gilbert, 1959 which was supplied to the Director
9 by Winley-Morris, is that out of date now? This document?

10 MR. GILBERT: Partially.

11 MR. MacLEOD: Would the prices set out in
12 this document be what are known in the trade as list prices,
13 that is suggested prices to the consumer?

14 MR. GILBERT: Yes. However, we had a more
15 than normal discount arrangement which was known on a
16 confidential basis to the various classes.

17 MR. MacLEOD: What do you mean by that?
18 That you could not take these prices and take 40 or 50%
19 off? You would have to take more?

20 MR. GILBERT: The doctors would get 50%
21 from that list price; the druggist 60%, which would be
22 as effective as the 20% discount on the net price.

23 MR. MacLEOD: So that your discount from
24 your list prices would have been larger than the discounts
25 allowed by some other manufacturers at least?

26 MR. GILBERT: Yes.

27 MR. MacLEOD: What was the purpose of that
28 policy?

29 MR. GILBERT: Well I will be candid and
30 say we set the list price on that basis in order to give a



1 better incentive to the druggists to market our products.

2 MR. MacLEOD: I have not marked this, Mr.
3 Chairman. This book that I have been discussing with Mr.
4 Gilbert will be among the material supplied to the
5 Commission because it is part of the information gathered
6 from various companies but it may be that because it has
7 been specifically discussed it should be marked.

8 THE CHAIRMAN: We can mark it as an exhibit.

9 MR. GILBERT: I have another copy here if
10 you want it.

11 THE CHAIRMAN: I think I have seen one of
12 them.

13
14 ---EXHIBIT NO. T-19: Copy of Mr. Gilbert's
15 drug catalogue.

16 MR. MacLEOD: Is there anything else you
17 want to say about your discounts? I propose to go to
18 other areas now.

19 MR. GILBERT: Well, in the event the
20 question should arise later, I will say that we also
21 offer a 20% discount from the net price to hospitals. This
22 is on a tax exempt basis. This means that the druggist
23 has an advantage in that if they want to sell our products
24 to a hospital, they can reclaim the tax which is included
25 in the price.

26 MR. MacLEOD: Does that mean that you would
27 sell to a retailer and a hospital at exactly the same
28 price?

29 MR. GILBERT: That is right, but one would
30 be tax included, the other would be tax exempt so effectively



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1 we are selling at a lower price to the retailer. This
2 was in a effort to give them an incentive also to handle
3 our products even if they wanted to sell to hospitals.

4 THE CHAIRMAN: That means that if the druggist
5 sells to the hospitals he reclaims that from you, not from
6 the government?

7 MR. GILBERT: No, from the government.

8 THE CHAIRMAN: And you absorb that?

9 MR. GILBERT: We pay the tax to the govern-
10 ment when we sell to the retailers.

11 THE CHAIRMAN: I say you absorb that tax?

12 MR. GILBERT: That is right.

13 MR. MacLEOD: Have you expanded your
14 facilities since you entered the pharmaceutical field in
15 1957?

16 MR. GILBERT: Well we have been buying some
17 additional equipment. Since 1957? No. Our plant was
18 only a year and a half old.

19 MR. MacLEOD: I thought your brief said you
20 entered the field in 1957.

21 MR. GILBERT: At that time I was doing
22 custom purchasing. I was not doing any manufacturing at
23 that time.

24 MR. MacLEOD: At that time you were buying
25 your dosage forms in bulk quantities and selling them?

26 MR. GILBERT: That is right.

27 MR. MacLEOD: That is the point I want to
28 get at. You have since increased your plant facilities
29 have you?

30 MR. GILBERT: Yes. I mean we have a complete



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1 pharmaceutical plant -- well, relatively complete.

2 MR. MacLEOD: And are you preparing more
3 of your own dosage forms as time goes on?

4 MR. GILBERT: Yes.

5 MR. MacLEOD: And I think you told me you
6 estimated 70% was it?

7 MR. GILBERT: About 70% of our sales are
8 manufactured in our plant.

9 MR. MacLEOD: Is it your intention to
10 increase that percentage?

11 MR. GILBERT: As much as possible, yes. We
12 want to go into different forms of manufacturing. We
13 hope ultimately to go -- to have a sterile area so that
14 we can actually package antibiotics.

15 MR. MacLEOD: You are not able to do that
16 now are you?

17 MR. GILBERT: Not at the moment.

18 MR. MacLEOD: You said something about a
19 sterile area. Are you drawing a distinction between
20 preparing injectable forms and capsules and tablets?

21 MR. GILBERT: That is right. This would
22 have to be a licensed area by the Food and Drug
23 Department.

24 MR. MacLEOD: Yes. I just wanted to get
25 this clear. Is it that you can now prepare capsules and
26 tablets of antibiotics?

27 MR. GILBERT: The oral forms are permitted.

28 MR. MacLEOD: The oral forms but you cannot
29 prepare the sterile injections?

30 MR. GILBERT: No.



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1 THE CHAIRMAN: Are you actually preparing
2 oral forms of antibiotics?

3 MR. GILBERT: Yes. We are making antibiotic
4 tablets and antibiotic capsules.

5 MR. MacLEOD: What about sources of drugs,
6 are basic drugs which you use in your preparation of dosage
7 forms available in Canada or some of them only or what
8 is the situation?

9 MR. GILBERT: Well, some are available in
10 Canada but I would say -- I would guess that less than 5%
11 are manufactured in Canada.

12 MR. MacLEOD: Less than 5% are manufactured
13 in Canada and do you in fact buy any from Canadian manu-
14 facturers?

15 MR. GILBERT: If the price were comparable,
16 we would certainly give them preference.

17 MR. MacLEOD: What is your experience as to
18 price between Canadian manufacturers and other sources.

19 MR. GILBERT: Well the best illustration I
20 can give you is Fine Chemicals are now selling to specific
21 companies chloramphenicol under licence at a price of
22 \$208.00 a kilo against the world market price of about
23 \$34.00.

24 MR. FRAWLEY: \$34.00 a kilo?

25 MR. GILBERT: That is right.

26 MR. MacLEOD: That is the approximate price
27 that you pay?

28 MR. GILBERT: Yes.

29 MR. MacLEOD: Plus I suppose duty?

30 MR. GILBERT: Plus duty, et cetera, but it is



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1 relatively insignificant against the \$200.00 price.

2 MR. FRAWLEY: When you say a world price for
3 chloramphenicol can you buy chloramphenicol in the United
4 States?

5 MR. GILBERT: No, not unless Parke Davis
6 were willing to sell it.

7 MR. MacLEOD: Is that because of patent
8 control in the United States?

9 MR. GILBERT: Yes.

10 MR. MacLEOD: Can you buy it in England?

11 MR. GILBERT: I think it is available from
12 England.

13 MR. MacLEOD: Do you know if you can buy
14 it without getting into patent difficulty?

15 MR. GILBERT: I have had offers from England,
16 yes. I have never bought it from England. I have had
17 offers.

18 MR. MacLEOD: How does the English price
19 compare with the price you were offered from other sources?

20 MR. GILBERT: They run close to the world
21 price. They try to be fairly competitive.

22 MR. MacLEOD: Now what are some of the
23 places that you can buy chloramphenicol at this price of
24 \$34.00 a kilo?

25 MR. GILBERT: The basic source is from Italy.
26 As a matter of fact, Parke Davis last year imported
27 30,000 kilos of chloramphenicol from Italy at a price of
28 \$30.00 a kilo.

29 THE CHAIRMAN: I am wondering, Mr. Gilbert,
30 if you can tell us a little more clearly just what you mean



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1 by the "world price"? Now looking at this chloramphenicol
2 there is quoted a price in Canada which is not the world
3 price, as you say. You cannot get it from the United States.
4 You can get it possibly from one source if they are willing
5 to sell it. That would not indicate a world price. You
6 say the British price is close to the world price. What
7 is the world price?

8 MR. GILBERT: This is in accordance with --
9 there is a free economic situation, unless you have a
10 cartel arrangement. If you have a big order to place,
11 and I have recently placed an order for 4,500 kilos of
12 chloramphenicol palmitate, I was able to arrange a price
13 of less than \$34.00 on a thing which I had previously
14 bought at about \$50.00. In other words, it is open to
15 negotiation and marketing.

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/dpw

1 MR. GILBERT: I mean no fixed price, and
2 if a big order is available you can generally jockey
3 yourself into a good position.

4 THE CHAIRMAN: What you mean by "world
5 price" is apparently a variable according to the circum-
6 stances at any particular moment and the quantity you
7 desire to buy?

8 MR.GILBERT: It fluctuates all the time
9 and with the market. I started buying tetracycline at
10 \$275 a kilo and my last price was \$89.

11 THE CHAIRMAN: I am trying to get what you
12 mean by the term "world price".

13 MR. GILBERT: It is not a fixed situation.
14 It is variable depending, maybe, on sun spots. I don't
15 know. The point to bring out is there is such wide
16 variation between the cost of manufacturing and the actual
17 selling price so that it is only the economy itself deter-
18 mining, which will determine what the manufacturer will
19 sell it for. There is no such thing, unless there is
20 cartelization, as a fixed price on a drug. You will find
21 chloramphenicol will be normally offered at \$40, but if
22 you know how you may get it at \$35. The \$40 would be a
23 guide. You might consider it at the time the world price.

24 MR.MACLEOD: In any event, Mr. Gilbert, your
25 evidence is to the effect you could go into the world markets
26 and buy chloramphenicol at \$35 when the price being charged
27 by certain aCanadian manufacturer was \$208.

28 MR. GILBERT: Right.

29 MR. MACLEOD: One other point, can you, in
30 fact, buy it from that Canadian manufacturer?



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1 MR. GILBERT: In fact, no.

2 MR. MACLEOD: Why has he refused to sell
3 you?

4 MR. GILBERT: There has been an absolute
5 refusal. The reason would be his.

6 MR. MACLEOD: Do you buy any drugs from
7 that particular manufacturer?

8 MR. GILBERT: Yes.

9 MR. MACLEOD: Do you have any difficulty
10 in connection with other drugs?

11 MR. GILBERT: There is no difficulty with
12 freely offered drugs, but the particular firm in question
13 has a few licences and they select the customers they
14 will sell to. They are very selective. The annoying
15 part of it is this particular company has a preference
16 as being a made in Canada item.

17 MR. MACLEOD: Can you buy meprobamate from
18 that company?

19 MR. GILBERT: No.

20 MR. MACLEOD: Have you tried?

21 MR. GILBERT: I have tried. I wouldn't buy
22 it there anyway.

23 MR. MACLEOD: Do you buy reserpine?

24 THE CHAIRMAN: You haven't tried very hard
25 if you wouldn't buy it.

26 MR. GILBERT: Their price is about five
27 times normal.

28 MR. MACLEOD: Does it come down to this,
29 Mr. Gilbert, in respect of drugs in which patents are held
30 by somebody, you have difficulty in buying them in Canada?



1 MR. GILBERT: True.

2 MR. MACLEOD: But drugs in respect of which
3 there are no existing patent rights, you can buy freely?

4 MR. GILBERT: Right.

5 MR. MACLEOD: Do you find any difference in
6 the Canadian price of these two different classes of drugs
7 as compared to the world price or the prices you can obtain
8 in other parts of the world?

9 MR. GILBERT: I would say on the whole
10 that the prices of this particular company take advantage
11 of the duty protection that is held, and they try to keep
12 it within a few cents of the duty paid world price. I
13 think this would be their policy.

14 THE CHAIRMAN: Where there are patents is
15 there a bigger spread? Perhaps I am anticipating Mr.
16 MacLeod.

17 MR. MACLEOD: That was going to be my ques-
18 tion.

19 MR. GILBERT: There is a tremendous spread.

20 THE CHAIRMAN: There is a great difference?

21 MR. GILBERT: Oh yes, not even close.

22 THE CHAIRMAN: In the case when we are
23 dealing with a patented article, where the process is
24 patented?

25 MR. GILBERT: That is right.

26 THE CHAIRMAN: As compared to the cost
27 where you were dealing with non-patented?

28 MR. GILBERT: Correct.

29 MR. MACLEOD: Is Italy the major source of
30 the lower price drugs?



1 MR. GILBERT: Yes.

2 MR. MACLEOD: That is you can normally buy
3 a particular drug in Italy more cheaply than anywhere
4 else in the world?

5 MR. GILBERT: You can use the Italian price
6 as a guide so that if you have a particular order to
7 place that you can probably get it about the same price
8 from other sources if the business is available.

9 MR. MACLEOD: What would be some of the
10 other sources, Denmark?

11 MR. GILBERT: Denmark.

12 MR. MACLEOD: Any others?

13 MR. GILBERT: Switzerland, and Hungary is a
14 big factor in chloramphenicol.

15 MR. MACLEOD: Do you know by whom the
16 chloramphenicol which you allege was imported by Parke-
17 Davis, was manufactured in Italy? MR. GILBERT: Farmitalia.

18 MR. MACLEOD: Would they be a source of supply you would
19 go to? MR. GILBERT: No, I wouldn't be able to buy
20 from them. I suppose that would be one of the stipula-
21 tions of Parke-Davis buying from that company.

22 MR. MACLEOD: In any event, you couldn't
23 buy from the same supplier?

24 MR. GILBERT: No.

25 MR. MACLEOD: Based on your experience, can
26 you give the Commission any information on the quality
27 of the basic drugs you obtain from Italy or from Denmark?

28 MR. GILBERT: We have the occasional diffi-
29 culty. I haven't been very happy with the finished pro-
30 ducts. That was one of the motivations for doing my own



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1 manufacturing, but we would have no complaint with the
2 material because we only buy on specification.

3 MR. MACLEOD: Does it, in fact, meet your
4 specifications?

5 MR. GILBERT: If it isn't we don't use it.
6 There have been the odd instances.

7 MR. MACLEOD: Do you find it possible by
8 using specifications to get basic drugs of high quality
9 from Italy?

10 MR. GILBERT: Yes.

11 THE CHAIRMAN: One further question in
12 connection with this Parke-Davis purchase from Italy.
13 You said you wouldn't be able to buy from the same firm,
14 Farmitalia.

15 MR. GILBERT: I believe that is the name.

16 THE CHAIRMAN: Have you ever got chloram-
17 phenicol from them?

18 MR. GILBERT: No.

19 THE CHAIRMAN: Have you ever tried?

20 MR. GILBERT: I believe I did.

21 THE CHAIRMAN: Have you tried to buy since
22 the Parke-Davis purchase?

23 MR. GILBERT: I am not sure, but I may have
24 approached them. I am not sure. I had the impression
25 it would be useless.

26 THE CHAIRMAN: On what was that based?

27 MR. GILBERT: Because I have applied to
28 this particular company before. I think there is some
29 form of cartelization arrangement between the American
30 patent holders and this company. They are not very



1 successful, but they do try.

2 THE CHAIRMAN: You have on another occasion
3 tried to obtain drugs subject to American patents?

4 MR. GILBERT: That is correct.

5 THE CHAIRMAN: And they have refused?

6 MR. GILBERT: Certain companies I approached.

7 THE CHAIRMAN: This Italian company has
8 refused to sell you drugs in the same circumstances?

9 MR. GILBERT: That is right.

10 MR. MACLEOD: What about other non-patented
11 drugs, have you tried to buy such drugs from this parti-
12 cular company?

13 MR. GILBERT: No, I have made no effort on
14 that.

15 MR. MACLEOD: You said a moment ago that
16 you found you were somewhat dissatisfied with some pre-
17 pared dosage forms you purchased. What has been your
18 experience there? Would you elaborate on that?

19 MR. GILBERT: The products assayed all
20 right. I wouldn't consider them pharmaceutically elegant.

21 MR. MACLEOD: Did you say for that reason
22 you had discontinued importing some of these forms?

23 MR. GILBERT: Correct.

24 THE CHAIRMAN: I am intrigued with the
25 phrase "pharmaceutically elegant". Is that a pharmaceu-
26 tical term?

27 MR. GILBERT: I think a pharmacist would
28 understand what I am talking about.

29 THE CHAIRMAN: We may not.

30 MR. GILBERT: You want a product you can



1 handle and look at with pride, clear-cut tablets, proper
2 shapes, unmottled, packaged properly.

3 THE CHAIRMAN: It relates to the appearance
4 of it?

5 MR. GILBERT: That is correct. It has
6 nothing to do with the quality, the intrinsic quality
7 of the drug.

8 THE CHAIRMAN: Nothing to do with the intrinsic
9 quality or safety?

10 MR. GILBERT: That is correct.

11 MR. MACLEOD: Do you purchase either basic
12 drugs or prepared dosage forms of drugs in the United
13 States?

14 MR. GILBERT: Yes.

15 MR. MACLEOD: Do you find you are able to
16 purchase these at as good a price as you can purchase
17 them elsewhere?

18 MR. GILBERT: In some instances of highly
19 competitive items, possibly, but we find it much cheaper
20 to manufacture these things ourselves because of the duty.

21 MR. MACLEOD: What duty would be applicable
22 there?

23 MR. GILBERT: On a finished product, duty
24 of 20%.

25 MR. MACLEOD: I take it from what you have
26 said these would largely be unpatented drugs?

27 MR. GILBERT: Right.

28 MR. MACLEOD: You would obtain from the
29 United States in dosage form?

30 MR. GILBERT: Unless a particular company is



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1 selling under a licence. We had one suit with Schering
2 on chlor-tripolon, which is chlorophenpyridamine, which
3 is freely available in the States under licence. However,
4 Schering has objected to our buying this product and is
5 suing us in Canada, even though it was a royalty paid item
6 in the United States.

7 MR. MACLEOD: These prices you gave, \$208
8 a kilo and \$34 a kilo, are these delivered prices or do
9 you have to pay duty on this?

10 MR. GILBERT: We have to pay duty. It is
11 20% now because it is of a class or kind made in Canada.

12 MR. MACLEOD: Taking these two figures which
13 I noted down, \$208, if you could buy from Fine Chemicals
14 at \$208 that would be your final cost?

15 MR. GILBERT: That would be the landed cost.

16 MR. MACLEOD: Would there be any significant
17 transportation or packaging charge or anything like that?

18 MR. GILBERT: Even the airfreight is insigni-
19 ficant when you are getting it from abroad on a high price
20 item.

21 MR. MACLEOD: It would be still less signifi-
22 cant in Canada?

23 MR. GILBERT: Definitely.

24 MR. MACLEOD: To the \$34 you have to add 20%
25 for duty?

26 MR. GILBERT: And possibly the airfreight.

27 MR. MACLEOD: Pardon?

28 MR. GILBERT: And possibly the airfreight
29 which may run about \$1 a kilo.

30 MR. MACLEOD: You could bring it in by air



1 for \$1 a kilo?

2 MR. GILBERT: Right, a dollar and a few
3 cents, in that neighbourhood.

4 MR. MACLEOD: Do any of these drugs because
5 of their quality of stability or anything like that, have
6 to be brought in by air rather than ordinary transporta-
7 tion?

8 MR. GILBERT: Primarily a question of time,
9 I think it is better to bring it by air because of the
10 value of the merchandise and the time involved.

11 MR. MACLEOD: What have you to say, Mr.
12 Gilbert, about the quality of the drugs which you sell
13 under generic names as compared to the quality of brand
14 name products which are on the Canadian market?

15 MR. GILBERT: I like mine better.

16 MR. MACLEOD: Can you give the Commission
17 anything from your experience that would enable them to
18 make a judgment as to the comparative qualities?

19 MR. GILBERT: We recently had a rejection
20 on one product which is a very difficult product to make,
21 but when we sat it side by side with the brand name pro-
22 duct, which was the original, the Department had to back-
23 track because our product, in fact, did look better.

24 THE CHAIRMAN: Is it a question of appea-
25 rance?

26 MR. GILBERT: Yes, it had nothing - it is
27 strictly a question of pharmaceutical elegance.

28 MR. MACLEOD: Have you any complaints
29 about your products not containing the requisite amount
30 of the drug as stated on the label, anything like that?



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1 MR. GILBERT: Our complaints are running
2 on the high side.

3 MR. MACLEOD: I beg your pardon?

4 MR. GILBERT: Our complaints are running
5 on the high side.

6 MR. MACLEOD: That is your products contain
7 more of the drug?

8 MR. GILBERT: Yes.

9 MR. MACLEOD: Than is stated on the label.
10 Is that also considered a defect in a product?

11 MR. GILBERT: Well, it would fall outside
12 the realm of specifications. Generally it happens percen-
13 tially, a fraction of a point which could very well be
14 an error in analysis. I mean, they are that close. There
15 have been one or two instances of that nature where a
16 product might have 105.3 and the limit was 105.

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JW/hm

- 1 MR. MacLEOD: Yes.
2 MR. GILBERT: We had one rejection on account.
However, our own analysis showed it to be 103.5.
3 However, we had to take it back.

4 MR. MacLEOD: What I am trying to do, Mr.
5 Gilbert, is -- you can come in here and say your products
6 are the best in the world, and somebody else can come in
7 and say they are the worst in the world, and it is a matter
8 of argument. I wonder if you could more or less document
9 the fact that either your products are as good as others
10 or not.

11 MR. GILBERT: Well, we have analysis for
12 all our products.

13 MR. MacLEOD: Is that part of your quality
14 control?

15 MR. GILBERT: Definitely.

16 MR. MacLEOD: Do the studies that you are
17 able to make enable you to form any conclusion as to the
18 relative quality of your product as regards the brand
19 named products?

20 MR. GILBERT: I know of my own personal
policy in my company and my employees fall in with that,
21 we want to give the best available, we want to give more
22 rather than less, because there is sufficient profit even
23 at our prices to enable us to do it, so that we don't want
24 to have any criticism whatsoever in that direction.

25 MR. MacLEOD: Do you know if your products
26 are in fact tested from time to time by the Food and Drug
27 laboratory?

28 MR. GILBERT: I think I was told at one
29 period of time there must have been ten samples a day coming



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1 into the Food and Drug up in Ottawa from various sources
2 throughout the country, but we have never had any com-
3 plaints.

4 MR. MacLEOD: That is persons outside your
5 own organization were sending in your own products for
6 testing?

7 MR. GILBERT: Even competitive manufacturers.

8 MR. MacLEOD: And you say the results of
9 those tests were what?

10 MR. GILBERT: Well, we never had any com-
11 plaint, therefore we presume that they are okay.

12 MR. MacLEOD: I think you said a moment
13 ago that on the prices that you charge, you are able to
14 make what you regard as an adequate profit?

15 MR. GILBERT: Right. You can take a simple
16 analysis. It would not take you too long to figure out,
17 let us say, what the profit is in 100 capsules of chloram-
18 phenicol, when you know that chloramphenicol costs me less
19 than \$40.00 a kilo. I think you should rather be ashamed
20 to have it brought out. I am still charging too much.

21 MR. MacLEOD: From your experience in the
22 industry, are you able to express any opinion to the
23 Commission as to whether or not large companies offering
24 their products under brand name have greater expenses for
25 quality control or anything of that nature than you have?

26 MR. GILBERT: I don't think you can make a
27 particular classification. I know that the Pharmaceutical
28 Manufacturers Association likes to talk about expensive
29 equipment which exists, perhaps in one or two plants, to
30 try to convey a picture for themselves as being done by the



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1 Pharmaceutical Manufacturers Association right down the
2 line.

3 I would say roughly that if you were to
4 classify my plant against those which exist within the
5 Pharmaceutical Manufacturers Association, you would
6 definitely have to classify me within the upper 20%. So
7 you have variations from beautiful plants down to nothing
8 right within the organization.

9 MR. MacLEOD: You feel that your plant would
10 rank among the best 20% in Canada?

11 MR. GILBERT: Yes.

12 MR. MacLEOD: And you feel that you spend
13 proportionately as much on quality control as do what we
14 might term the most highly reputed manufacturers?

15 MR. GILBERT: If by "proportionately" you
16 mean percentagewise, I would say so, yes.

17 MR. MacLEOD: And you think that a product
18 that goes out of your plant is as adequately tested before
19 it goes out as in the case of highly reputed manufacturers?

20 MR. GILBERT: I have two employees who used
21 to be with Merck Company who are controlling my plant, and
22 they are eminently satisfied with the way we are carrying
23 on our operation.

24 THE CHAIRMAN: Did they do the same kind
25 of work for Merck that they are doing for you?

26 MR. GILBERT: Right.

27 THE CHAIRMAN: Are they employees who are
28 in charge of your quality control measures?

29 MR. GILBERT: Right. One is a production
30 man and controls production and controls the analytical



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1 laboratory in charge of all process controls, and the
2 other is our packaging man which is an important feature.

3 THE CHAIRMAN: Do you have a chemical
4 analyses at various stages of manufacturing?

5 MR. GILBERT: Well, our chemical analyses
6 are performed as follows: If you are interested in the
7 methods of quality control in our plant, I have written a
8 letter to a very large hospital in Calgary including that
9 question, and if you want me to read it into the record,
10 I think it might answer a lot of your questions.

11 THE CHAIRMAN: I thought we would like to
12 have, Mr. Gilbert, all the information you could give us
13 about your methods and carefulness of application of your
14 quality control measures, because one of the things we have
15 been hearing quite a bit about is that there is a consider-
16 able variation in matters of quality control, and that so
17 far as purchases are concerned, a pharmacist who doesn't
18 know that a particular manufacturer's precautions are
19 adequate, will refuse to buy.

20 MR. GILBERT: I would observe at that point,
21 if you will forgive me, that the pharmacist generally does
22 not want to know.

23 THE CHAIRMAN: At the moment we are not
24 dealing with that. If he doesn't know and if there is
25 danger in buying because of products that are not safe and
26 are not uniform so that they can be dependable, then of
27 course they would be justified in not buying. We would
28 like to have on the record what your position is.

29 MR. GILBERT: This is a subject . I would
30 like to go into later if I may.



1 THE CHAIRMAN: We would like to know what
2 your quality control measures are and how they are carried
3 out as far as you can explain it without having your
4 equipment here.

5 MR. GILBERT: This is a letter addressed to
6 the Calgary General Hospital to the attention of J.C.
7 Johnson, M.D. who is medical director of this particular
8 hospital in response to a request from him.

9 "Gentlemen:

10 This will acknowledge your letter of June
11 15th. I regret not answering sooner because of attending
12 the Western Conference Hospital Association meetings.

13 We will first answer your questions in order,
14 and later will fill in any information which may throw
15 additional light on the subject.

16 All of our products are labelled in accordance
17 with an acceptable standard, when available, i.e. U.S.P.,
18 C.S., N.S. or B.P. When the product does not appear in
19 any of the above standards, we generally rely on the latest
20 issue of N.N.R."

21 -- which is New and Non-official Remedy.

22 Our original labels are always submitted
23 to the Food and Drug Department of the National Health
24 and Welfare for approval. Our products are guaranteed to
25 meet all the requirements of the standard named on the
26 label. While our products are frequently sampled and
27 tested by the Food and Drug Department, we still maintain
28 our own independent rigid controls.

29 It is our current policy to supply only
30 tested and proven products with existing quality control



1 monographs. When a new product is marketed, i.e.
2 Chlorothiazide, we must then file a new drug application,
3 which goes into all matters of quality control before
4 and after manufacture, testing procedures both chemical
5 and clinical, toxicity data, labelling and review of
6 accompanying literature and claims.

7 Quality Control Features:

8 1. Purchase of raw materials: (a) We
9 state the standards to which the raw
10 material must comply.

11 (b) We insist on elegant looking raw
12 materials, in addition to passing the
13 chemical control.

14 (c) We request the manufacturer's analyses.
15 2. On arrival of the new material, this
16 material is quarantined for the Polytechnic
17 Laboratories -- 19 Cordova Street -- samples
18 and analyses this material, to check the
19 manufacturer's standards."

20 THE CHAIRMAN: That is in Toronto?

21 MR. GILBERT: That is right.

22 "3. We maintain the formula cards for
23 all products:

24 (a) A new formula batchcard is made for
25 each product.

26 (b) Each weighing of material is kept by
27 a second employee.

28 (c) Weight of tablet, time of disintegration,
29 hardness, and appearance of tablet is kept
30 under period constant supervision.



1 (d) The finished tablets are put through
2 a brushing procedure to remove loose powder.

3 (c) On completion of the batch the pro-
4 duction is sampled again by the Polytechnic
5 Laboratories, who test in accordance with
6 the appropriate monograph covering the
7 product.

8 4. On receipt of analysis and assurance of
9 conformance, a batch of labels are stamped
10 with the appropriate lot number.

11 5. At this time, a new batch card is set
12 up covering the finished product, and the
13 total production and subdivision is entered
14 on this card.

15 The tablets or capsules are electronically
16 counted and inspected for defective tablets
17 as they are being bottled.

18 When orders are received, the invoice
19 number and quantity are entered on the
20 batch card. This insures our ability to
21 make a total recall of any production.

22 A representative sample of each lot is
23 maintained in a reference file.

24 RETURN POLICY:

25 In view of the controversial character of

26 the drug situation, we have an established policy of
27 unconditional guarantee -- any merchandise purchased is
28 returnable for full credit. Please note that this is not
29 a qualified guarantee, and that merchandise may be returned
30 whether justifiable or not justifiable."



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1 THE CHAIRMAN: Does that apply to broken
2 parcels as well as unopened ones?

3 MR. GILBERT: I think we would accept
4 broken parcels, but rightfully we should not.

5 THE CHAIRMAN: Most manufacturers according
6 to our information --

7 MR. GILBERT: -- would refuse to do that.

8 THE CHAIRMAN: Do not take back broken
9 parcels.

10 MR. GILBERT: But when we give this un-
11 conditional guarantee, I think we would accept it.

12 "The foregoing describes the technical
13 controls, but there are other features of our operation
14 which will indicate a form of public dedication and
15 employee interest, because the firm has a sense of public
16 interest, which purveys the atmosphere of our company.

17 Our company has spent considerable sums
18 to defend our right to question the existing patent
19 situation."

20 However this goes beyond the question of
21 quality control, so I will stop there.

22 THE CHAIRMAN: A question occurred to me,
23 we have had some statements to the effect that some of
24 the foreign manufacturers either of finished dosage forms
25 of drugs or of the raw material, have not the type of
26 quality control that is desirable for drugs to be sold in
27 Canada. I was wondering if you had taken any steps to
28 ascertain what the quality control measures are and how
29 they are carried out in the foreign companies from whom
30 you purchase your raw materials.



1 MR. GILBERT: Essentially my feeling is,
2 I think it is wrong to take anything on faith, even if a
3 company has a proper reputation, because things can slip
4 through even in a company of that nature. If the company
5 has a poor reputation, of course you have got to watch it,
6 definitely. However, we are primarily concerned with the
7 finished raw material which we get which must conform
8 both chemically and from the point of view of elegance.

9 THE CHAIRMAN: And the test that is made
10 en arrival, what is the name of that company again?

11 MR. GILBERT: The Polytechnic Laboratories.

12 THE CHAIRMAN: Polytechnic Laboratories
13 test them, and you are satisfied they do a complete test
14 en which you can rely?

15 MR. GILBERT: Definitely. I notice further
16 en in this letter, if you want me to read it in, I describe
17 my staff personnel.

18 THE CHAIRMAN: If you let us know the
19 qualifications of the staff that are involved in quality
20 control, we don't need to have all your staff.

21 MR. GILBERT: I am only talking about the
22 supervisory staff.

23 THE CHAIRMAN: You can tell us who they
24 are and what their qualifications are.

25 MR. GILBERT: "My own background is that of
26 a graduate pharmacist and chemical engineer, and have
27 worked in most phases of drug manufacture (synthesis),
28 drug compounding, drug research and drug marketing for
29 an elapsed period of 35 years.

30 Mr. Donald Dix, an engineer from the



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1 University of Saskatchewan had worked with Connaught Laboratories,
2 had helped erect and operate the Merck plant in
3 Valleyfield, Quebec. Had supervised the erection of a
4 number of antibiotic and D.D.T. plants in the far east
5 under the auspices of the United Nations. Mr. Dix possesses
6 a dedication to our objective to provide the best.

7 Mr. W. Damray had supervised the mixing
8 and packaging operations of Merck & Company in Valleyfield.
9 He has high production standards and is also dedicated to
10 our success."

11 THE CHAIRMAN: Was he a pharmacist or a
12 chemical engineer?

13 MR. GILBERT: No, I think he is a practical
14 technician.

15 THE CHAIRMAN: But the other one you
16 described previously is a graduate engineer?

17 MR. GILBERT: That is right.

18 "Mr. Harold O'Neill, plant foreman, has
19 30 years of practical experience in the art of tabletting--"
20 And I say "art" advisedly.

21 " -- coating and encapsulating.

22 There has been no employee turnover in
23 our pharmaceutical production department.

24 Our capsulating and banding equipment is
25 unique in Canada and will produce capsules with a plus
26 2% weight accuracy against a permissible deviation of
27 plus or minus 15%.

28 Regardless of the permissive deviations,
29 instructions are to arrive at a product of 100 to 101%.
30 A directive has been issued to the control laboratory to



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1 provide me with any analyses that are within 2% deviation
2 of the lower or upper quantitative limits.

3 Injectable antibiotics are routinely tested
4 and released by the Department of National Health and
5 Welfare.

6 Cleanliness and contamination control is
7 an important aspect of our operation to the extent that
8 we are prepared to receive visitors even though unannounced".

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WT/dpw

1 MR. MACLEOD: If that is all you want to
2 say on quality control, I will bring you back to some-
3 thing you said a moment ago. Did you say that you could
4 make some estimate of the profit on a particular drug by
5 taking the cost of the basic drug? What I am getting at,
6 it has been suggested many times that the basic drug is
7 only one small element, and it is unfair to say "Oh, the
8 drug costs a dollar, and it sells for \$15". That compari-
9 son does not give you any information. Is it your view
10 such comparison would give you any information?

11 MR. GILBERT: Definitely.

12 MR. MACLEOD: Why do you say that?

13 MR. GILBERT: Some companies who make these
14 claims can bid at those ridiculous prices and have shown
15 ability to do so, and I don't think they are being gene-
16 rous or philanthropic.

17 In other words, if Schering can bid \$9 a
18 thousand on Prednisone, they are making a profit at that
19 price, and they are selling it at that price. Why? Their
20 list or the policy price of this company is \$11.70 a
21 hundred.

22 THE CHAIRMAN: Do you know cases in which
23 Schering has bid \$9 a thousand?

24 MR. GILBERT: That is right. They beat us
25 out.

26 THE CHAIRMAN: In Canada?

27 MR. GILBERT: No, in the United States.

28 MR. MACLEOD: Is the capsuling of a drug
29 containing a single active ingredient an expensive opera-
30 tion?



1 MR. GILBERT: Well, your capsules generally
2 cost - the capsules themselves cost more than the actual
3 tabletting operation, and actually the operation is a
4 slower operation so that there is more labour involved.

5 I think I would say on the average you would
6 have about \$3 per 1,000 basic cost in the manufacture of
7 a product. That is the capsule and the labour.

8 MR. MACLEOD: Capsule and the label would
9 add \$3?

10 MR. GILBERT: And the labour. It would be
11 at least \$3 more expensive than an equivalent tablet.

12 MR. MACLEOD: Did you say the total cost
13 of capsuling 1,000 capsules would be \$3?

14 MR. GILBERT: Including the cost of the
15 capsules, approximately.

16 MR. MACLEOD: Now you spoke about the cost
17 of the ingredients. You would have some binders and
18 fillers and things like that, would you not?

19 MR. GILBERT: Negligible.

20 MR. MACLEOD: The cost of those would be
21 negligible?

22 MR. GILBERT: Right.

23 MR. MACLEOD: What additional costs are
24 involved if you have more than one active ingredient
25 where the ingredients must be mixed in a certain propor-
26 tion, and so on, before they are capsuled?

27 MR. GILBERT: Well, there would be no more
28 in making a capsule than there would be in making a
29 tablet because you have to control quantities and qual-
30 ties of the various ingredients regardless of whether it



1 is a tablet or a capsule, so that would be normal for
2 both.

3 MR. MACLEOD: What I am trying to get at,
4 is that an expensive operation?

5 MR. GILBERT: With us it is a fixed fee
6 regardless of how much we produce because we work on a
7 retainer basis with a laboratory.

8 MR. MACLEOD: The laboratory does it for
9 you?

10 MR. GILBERT: I beg your pardon?

11 MR. MACLEOD: The laboratory does it for
12 you?

13 MR. GILBERT: That is right.

14 MR. MACLEOD: So that you don't carry out,
15 where you have a product that contains more than one
16 active ingredient, you don't yourself carry out the
17 mixing of those ingredients?

18 MR. GILBERT: We do carry out mixing, yes,
19 but analytical quality controls - in other words, if we
20 know the materials going into the products are correct,
21 the next thing we have to be careful of is that the
22 weights are correct, and we have our own check procedures
23 on that; then we also have our quality control internal
24 procedures during this status of manufacturing.

25 MR. MACLEOD: Yes. If we can get this
26 clear, you told me in the case of a product containing
27 a single active ingredient, that the cost of any binder
28 or filler would be negligible?

29 MR. GILBERT: Relatively, yes.

30 MR. MACLEOD: The cost of capsuling might



1 be \$3 a thousand?

2 MR. MACLEOD: I might add sometimes the
3 basic material is negligible.

4 MR. MACLEOD: I am wondering about the cost
5 outside the material itself. Now, I am taking you on
6 now to the case where your dosage form contains more than
7 one active ingredient and you have to mix them?

8 MR. GILBERT: That is right.

9 MR. MACLEOD: What does the process of
10 mixing them - never mind testing for the moment - but what
11 does the process of mixing them and getting them in the
12 right proportion add to your cost?

13 MR. GILBERT: That is not serious even if
14 you make a single content tablet. You are always mixing
15 other ingredients which you have to check and weigh.
16 That is the part of the operation that would fall within
17 the cost of manufacturing a tablet which might be related
18 to basic cost of about 30¢ or 40¢ a thousand tablets pro-
19 duced.

20 MR. MACLEOD: Complete cost of producing
21 tablets might be 30¢ or 40¢ a thousand beyond the actual
22 cost of the ingredients?

23 MR. GILBERT: That is right.

24 THE CHAIRMAN: It is all done by machine?

25 MR. GILBERT: Machine, guided by people.

26 THE CHAIRMAN: But the actual mixing?

27 MR. GILBERT: That is right.

28 MR. MACLEOD: What is the cost of packages?
29 Do they add significantly to the total cost of preparing
30 dosage form?



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1 MR. GILBERT: Roughly I would say on a 100-
2 tablet package on the average it would cost, oh, 10¢ a
3 package, and maybe go up to 15 to 18¢ on a thousand-
4 package. That would include bottling, labelling, cost
5 of the label, bottle, cap, band. You have the whole
6 basis now if you are estimating your drug costs.

7 MR. MACLEOD: Would you look at the figures
8 that are set out at the top of page 154 of what we have
9 been calling the Green Book. Are you able to express any
10 opinion as to whether those are typical? Those are
11 figures for 1,000 packages, I believe.

12 MR. GILBERT: These figures, total cost
13 per 1,000 packages. Well, on that basis it works out to
14 about 19¢ a package. That is for 50's, and when you are
15 coming out to a price of about 19¢, you can't be too
16 far off.

17 MR. MACLEOD: You think those are fairly
18 typical?

19 MR. GILBERT: Just based on that one figure,
20 I would say that would be typical. I presume that the
21 same 19¢ package might sell for \$5 or \$6.

22 MR. MACLEOD: Well, that brings up the
23 point, Mr. Gilbert, that of necessity the price of the
24 packages may be extremely important in the case of a
25 product such as A.S.A. tablets?

26 MR. GILBERT: That is right.

27 MR. MACLEOD: But in the case of a package
28 of penicillin G tablets it would be relatively insignifi-
29 cant?

30 MR. GILBERT: Relatively unimportant. It



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1 is more important to sell the merchandise.

2 MR. MACLEOD: I thought, Mr. Chairman, I
3 might ask Mr. Gilbert to comment on patents next. That
4 might take some little time. Would that be a good time
5 to break?

6 THE CHAIRMAN: Yes. We will have a short
7 break.

8
9 --- Short Recess

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R/hm

1 ---following short recess.

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3 MR. MacLEOD: Perhaps just to complete what
4 we were discussing Mr. Gilbert, do you know of any costs
5 in the preparation of dosage forms that brand name manu-
6 facturers would have that you do not have? I am not
7 talking about promotion or anything like that. Just
8 actually preparing the products for sale.

9 MR. GILBERT: I would say if they are
10 running an efficient operation, I would have the same cost
11 that they would.

12 THE CHAIRMAN: If they are running an
13 efficient operation?

14 MR. GILBERT: That is right.

15 THE CHAIRMAN: If they are not, they would
16 have more costs than you would?

17 MR. GILBERT: That is right.

18 MR. MacLEOD: I think Mr. Gilbert the
19 Commission would be interested in hearing your views on
20 patents. Would you like to take that yourself rather than my
21 asking you specific questions?

22 MR. GILBERT: Well I will try and make a
23 little preamble on the thing and give my opinion generally.
24 I don't know how I will do, but I will try.

25 To begin with, I personally believe that the
26 patent law is the cornerstone which permits the drug
27 situation to exist that does in the States. In 1957 -- I
28 mean this is based on a long history -- I have found that
29 a great many drugs were freely available which I had not
30 known of before and I have always taken the stand personally



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1 that there is not a valid drug patent written. Now if that
2 were true ---

3 THE CHAIRMAN: You are talking about process
4 patents, are you?

5 MR. GILBERT: I am talking about Canadian
6 drug patents.

7 THE CHAIRMAN: There is a difference between
8 the American and Canada. You began to speak of the United
9 States.

10 MR. GILBERT: You are able to obtain drug
11 patents in Canada strangely enough in spite of the law.

12 THE CHAIRMAN: Is that what you mean,
13 partly what you mean when you say they are not properly
14 written?

15 MR. GILBERT: If you let me finish, I think--

16 MR. MacLEOD: Just to interrupt you very
17 briefly, on that particular point it is only a chemical is
18 it for which you can get a patent?

19 MR. GILBERT: That is a known drug chemical
20 for which you can get a process patent but I can give
21 instances of drug patents which are product patents which
22 are obtained regardless of the process.

23 MR. MacLEOD: Yes, but the process patent
24 is restricted to chemicals, is it not?

25 MR. GILBERT: Well Section 41 (2) says that
26 a patent when a product is used for food or medicine
27 you can only have a patent issued for the process of
28 manufacture or a patent for the product is given for a
29 specific process. However, you have instances of patents
30 for drugs which are strictly product patents regardless of



1 the process. Well it throws a blot on the patent laws
2 immediately.

3 THE CHAIRMAN: Are you suggesting that that
4 patent would stand up so that they would get a judgment
5 for an infraction, and infringement of the patent if some-
6 body else produced the same product on a different process?

7 MR. GILBERT: Well, the process -- in those
8 particular patents you have a patent for the product
9 regardless of the process. So as long as the product is
10 being sold you have infringed.

11 THE CHAIRMAN: It becomes a legal question
12 whether the patent would stand up in the courts?

13 MR. GILBERT: Of course, but getting back
14 to my own view of the patents, it has been my observation
15 that all patents are full of exaggerations and an exaggera-
16 tion is a lie. It is not the truth.

17 They are all too broad. They cover things
18 which are never used or never made. They are broad state-
19 ments covering products which -- possibly you can show
20 products which come within these classifications which would
21 actually be deleterious, poisonous or could not possibly
22 be used, or perhaps could not even possibly be made. The
23 purpose of these, the breadth of these patents is to
24 prevent research and competition within the field that this
25 patent covers.

26 Actually you will find that most patents
27 cover a single compound which is being marketed and behind
28 that it is like a thin wedge of a pie, the point of a
29 pie. It may cover millions of compounds behind which
30 nobody dare touch on the basis of the licence which has



1 been granted by the Canadian Patent Office.

2 It is used, so far as I am concerned, as a
3 blackmail technique to keep others out of the field. Now
4 we have had patent suits in the courts for four years.
5 We still have to see the completion of a single suit in
6 the courts.

7 That is my general view. I will be glad
8 to answer specific questions.

9 MR. MacLEOD: Well do you feel that the
10 existence of patents restricts competition in the field
11 in Canada?

12 MR. GILBERT: No question of it.

13 MR. MacLEOD: In what way does it do this?

14 MR. GILBERT: Well, if a patent which could
15 never stand up in court is being successfully prosecuted,
16 and generally the people who own these patents can very
17 well afford to go through all the legal technicalities
18 to prevent a smaller company from infringing a patent and
19 the infringer has to contemplate at least a \$30,000.00 cost
20 for each infringement just to defend himself whether he
21 is right or wrong.

22 MR. MacLEOD: The fact that a particular
23 company holds a patent on a particular drug, or the
24 process and producing that drug means that that company
25 is the only company which can sell that drug in Canada.
26 Is that so?

27 MR. GILBERT: No, it doesn't infer that at
28 all because all they have is a process patent and anybody
29 else who can find a different process can manufacture it,
30 but it has that effect I would say.



1 MR. MacLEOD: Has that been the experience?
2 For instance, was chloramphenicol manufactured in Canada
3 prior to obtaining a compulsory licence by certain other
4 firms?

5 MR. GILBERT: Well I think they still go
6 through a nominal phase or token form of manufacture
7 because otherwise they would need a different section of
8 the patent and you can force licensing if they did not
9 manufacture in Canada.

10 MR. MacLEOD: Yes, but what I was concerned
11 with was the actual effect in practice. To your knowledge
12 was chloramphenicol manufactured by anyone before a
13 compulsory licence was obtained?

14 MR. GILBERT: It was not manufactured by
15 anyone in Canada until I had started infringing their
16 patents and then at that time they took steps to start
17 manufacturing in Canada.

18 MR. MacLEOD: You have used chloramphenicol which
19 is Parke Davis' chloromycetin. Do you know of anyone
20 manufacturing that product besides Parke Davis?

21 MR. GILBERT: In Canada?

22 MR. MacLEOD: Yes.

23 MR. GILBERT: I understand that Fine
24 Chemicals are supposed to be manufacturing it.

25 MR. MacLEOD: Under licence?

26 MR. GILBERT: Yes.

27 MR. MacLEOD: Do you know if the manufacture
28 of tetracycline has been confined to those who hold
29 licences?

30 MR. GILBERT: I don't think that tetracycline



1 is manufactured in Canada, as yet.

2 MR. MacLEOD: Was it available from any
3 source in Canada, except to licensees?

4 MR. GILBERT: It was always an imported
5 product and it was only available to those companies which
6 had agreements with possibly Pfizer or American Cyanamid
7 or Bristol.

8 MR. MacLEOD: Can you express any opinion
9 as to the use which has been made of the compulsory licensing
10 provisions of the Patent Act?

11 MR. GILBERT: Well there is very little use
12 that has been made because you will only get a licence on
13 the basis of the manufacture of the product. In order to
14 go into the manufacture of a particular product you would
15 generally have to have an extensive plant. To build a
16 plant for the consumption that would be available in
17 Canada might be considered too costly and not worthwhile,
18 especially when these same materials could be procured
19 from Europe probably for less than it would cost you to
20 initially set up.

21 MR. MacLEOD: It has been suggested that
22 the very existence of the compulsory licensing provisions
23 means that a lot of licences are granted voluntarily.
24 Are you in a position to express any opinion as to this
25 situation?

26 MR. GILBERT: I have not been successful,
27 as yet. I have always offered to accept a licence from
28 every person who has threatened to sue me.

29 MR. MacLEOD: Yes, but could you express
30 any opinion as to the whole drug field, whether the



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1 existence of a compulsory licensing provision has meant
2 that companies could get such licences as they required
3 voluntarily?

4 MR. GILBERT: Providing they had a manu-
5 facturing plant and are prepared to manufacture the
6 product I know that it can be forced.

7 THE CHAIRMAN: That was not the question.
8 The question was has the existence of the compulsory
9 licensing provision in the act resulted in companies being
10 able to obtain a voluntary licence which they would not
11 have obtained without that provision in the Act?

12 MR. GILBERT: Simply on the basis. -- I
13 cannot exclude the licences which are granted because of
14 intercompany policies like perhaps Pfizer grants a licence
15 to Squibb to market tetracycline. They had no intention
16 of making tetracycline. I just want to differentiate from
17 them. So far as my experience shows every application
18 for compulsory licence has been fiercely contested by the
19 company involved.

20 THE CHAIRMAN: Is that only your own
21 experience? Have you applied for a licence and be told
22 you could not get it?

23 MR. GILBERT: Yes. I prosecuted personally
24 a licence application for chloramphenicol against Parke
25 Davis and was fiercely contested.

26 Of course, I took the stand that since they
27 had a product patent, which I thought was wrong in the
28 first place, therefore the element of manufacture should
29 not be necessary as a consideration for licensing. The
30 opinion of the Commissioner was reversea. I did not get



1 the licence but the opinion of the Commissioner was
2 reversed by the court but at that particular time we had
3 already succeeded in setting aside an injunction which
4 Parke Davis had against our company and we proceeded to
5 market on our own basis.

6 THE CHAIRMAN: You did not get a licence
7 as the result of that?

8 MR. GILBERT: I think if we would have
9 insisted on it we could have gotten it but it would have
10 been a tough fight.

11 THE CHAIRMAN: The thing is, you are con-
12 tending that the patent is invalid. In respect to the
13 licence you may prejudice your position.

14 MR. GILBERT: I am still willing to accept
15 a licence in all cases.

16 MR. MacLEOD: A point I raised with you
17 before, Mr. Gilbert, is in connection with section 41 (1)
18 of the Act which reads: "In the case of inventions
19 relating to substances prepared or produced by chemical
20 processes and intended for food or medicine, the specifica-
21 tions shall not include claims for the substances itself."
22 Now, apparently anything that is produced by chemical
23 process would be outside this restriction. Can you
24 express any opinion as to whether materials not produced
25 by chemical process are important in the pharmaceutical
26 field? Are there products which can be patented as products?

27 MR. GILBERT: I don't know of any.

28 MR. MacLEOD: You don't know of any?

29 MR. GILBERT: No.

30 MR. MacLEOD: Now I think perhaps we are clear



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1 on this compulsory licensing business but just to be sure,
2 the situation I was putting to you was this: Company A
3 wants a compulsory licence from Company B. Now it has
4 been suggested that Company A can go to Company B and say
5 "If you don't give it to me voluntarily, I will go to the
6 Commissioner and get it" and that this very fact has meant
7 that in a good many such situations, B gives the licence
8 anyway.

9 MR. GILBERT: I don't know of any instances.
10 Perhaps you can tell me.

11 MR. MacLEOD: I am just asking for your
12 experience.

13 MR. GILBERT: I don't know of any instances.

14 MR. MacLEOD: Do you have any opinion about
15 the desirability of using generic names or brand names,
16 and if so, what is your opinion?

17 MR. GILBERT: I think from many aspects it
18 is most desirable that drugs be sold -- you are using the
19 term generic. I prefer to use proper name of the drug
20 which would refer to the one by which it is commonly
21 technically understood. I find that most technical papers
22 generally make it a point and sometimes will apologize if
23 they use a brand name of the drug within their discussions
24 of this particular drug.

25 Now from the medical point of view it means
26 that the doctor can study a product on the basis of its
27 descriptions, the papers published all under one common
28 name, and he learns to know the properties of these drugs,
29 whatever their action is, by a single name which would be
30 generally accepted in the field and you have only one name



1 to contend with.

2 It also means, I think, that doctors, if
3 they work on this, probably will have a much better
4 medical practice because when you go back to the brand
5 name you are strictly subject to the blandishments of the
6 company that is putting out this particular product.

7 From the point of view of the pharmacist,
8 it would be one name which gives the pharmacist an
9 opportunity to properly control his inventory. He does
10 not have to have many different products of the same
11 composition on his shelf to satisfy the whims of different
12 people.

13 THE CHAIRMAN: Is chloramphenicol the
14 proper name?

15 MR. GILBERT: Yes.

16 THE CHAIRMAN: In your opinion, as I take
17 it, chloramphenicol would be better marketed as Gilbert's
18 chloramphenicol, Parke Davis' chloramphenicol?

19 MR. GILBERT: That is right.

20 THE CHAIRMAN: Upjohn's Chloramphenicol,
21 whatever it is?

22 MR. GILBERT: That is right.

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35 "B/dpw

1 MR. GILBERT: I am fully in agreement with
2 that and I think ultimately this will be the future in
3 the pharmaceutical marketing program, that it will be by
4 specification by the proper name with a preference shown
5 to the company who can fulfil the requirements of what
6 the doctor wants. It could be a company itself. Perhaps
7 it could be the fact he knows if he mentions a certain
8 name he can get a better price because of the price list.
9 At least he can control the economic implications of the
10 medication.

11 THE CHAIRMAN: We have had it suggested to
12 us very strongly on several occasions that each manufac-
13 turer has some small variation in preparation of a product,
14 the essential ingredients of which are the same, and that
15 it will operate a little differently, it may dissolve a
16 little more quickly, it may have a longer lasting property
17 or something about it may lead to a somewhat different
18 physiological result, therapeutic result, and conse-
19 quently there is a distinction which sometimes is made
20 even though the proper name or generic name as Mr. MacLeod
21 said may be the same.

22 MR. GILBERT: When you are using the brand
23 name or using it under the proper name, if the doctor
24 likes a particular property of some product he can still
25 stipulate it shall be company X's product.

26 THE CHAIRMAN: You said you anticipate that
27 is the future?

28 MR. GILBERT: That is right.

29 THE CHAIRMAN: Do you look for it in the
30 near future?



1 MR. GILBERT: It could be overnight if the
2 country went ahead.

3 THE CHAIRMAN: It could be overnight, but
4 are you anticipating it?

5 MR. GILBERT: Not for a long time yet. It
6 is going to be a tough battle.

7 THE CHAIRMAN: We haven't heard of any
8 trend in that direction.

9 MR. MACLEOD: Mr. Gilbert, has your
10 experience shown you that the brand name is important in
11 the commercial sense as affecting the sales of a particular
12 product?

13 MR. GILBERT: Well, from a point of view of
14 a company putting out a product who intends to spend
15 millions in simply promoting etc., they are naturally
16 going to pick up a particular brand so the business they
17 are trying to encourage is directed to their product.

18 MR. MACLEOD: Do you think the way brand
19 names are used in the pharmacy field has an appreciable
20 effect on the sale of the particular product to doctors
21 or prescriptions written by doctors?

22 MR. GILBERT: Definitely, very often a
23 doctor doesn't know the different name at all; that is,
24 the proper name, is not consciously aware of it. It is
25 a sad statement to make, but I think that is true.

26 MR. MACLEOD: You said something about
27 filing a copy of the brief which you submitted to the
28 Ontario Select Committee. Do you have a separate copy?

29 MR. GILBERT: I only have this one copy
30 here.



1 MR. MACLEOD: Your brief, I believe, is set
2 out in Volume 14?

3 MR. GILBERT: That is the copy that I have.

4 MR. MACLEOD: This document I am showing
5 you, Volume 14 of the proceedings before the Ontario
6 Select Committee, sets out your brief, does it?

7 MR. GILBERT: Yes.

8 MR. MACLEOD: We should perhaps mark this.

9 THE CHAIRMAN: It will be Exhibit T-20.

10
11 --- EXHIBIT NO. T-20: Volume 14 of the Proceedings
12 before the Ontario Select
Committee.

13

14 MR. MACLEOD: There is one other point:
15 would you amplify on your experience in selling in foreign
16 markets. You said you were able to go into world markets
17 and compete.

18 MR. GILBERT: Well, I find that when I
19 compare mine, let us say, with an Italian manufacturer
20 of finished products, I find that I can sell at approxi-
21 mately the same price. That is talking about the finished
22 product. Perhaps I can do even more and get a lower
23 price than they are putting in. In exporting we get the
24 duty back which puts me on a common basis with the source
25 of supply in Italy. Very often being an importer some-
times you can work a better price than you can get locally.

27 THE CHAIRMAN: That rather suggests, Mr.
28 Gilbert, that you don't incur anything like the same pro-
29 motion expenses as other manufacturers say they have to
30 incur in order to compete with the Canadian market?



1 MR. GILBERT: To compete on what market?

2 THE CHAIRMAN: They have the promotional
3 expenses which could affect the price they could sell
4 anywhere.

5 MR. GILBERT: I think that is a question of
6 what they want to spend, isn't it?

7 THE CHAIRMAN: You said that you could
8 compete abroad with products which you have bought from
9 abroad against manufacturers abroad who have used those
10 materials, you can compete successfully. That rather
11 indicates that you don't, yourself, in your business,
12 incur anything like the same promotional expenses as
13 other Canadian manufacturers do. They have given us the
14 view that much higher costs of promotional expenses in
15 the United States and Canada have much to do with the
16 higher price here than in Europe.

17 MR. GILBERT: I think we would have to get
18 our points of reference on common ground before I could
19 discuss it intelligently.

20 THE CHAIRMAN: If the costs of promotion
21 and advertising are what we have been told they are, it
22 would be very difficult to compete as you are able to do.

23 MR. GILBERT: May I explain on this, let
24 us say company X has 30% promotional expense for marketing
25 in Canada but he doesn't have it for marketing in Thailand
26 This production will be over and above his normal
27 requirement in Canada, on that basis he could figure the
28 basis of his cost.

29 THE CHAIRMAN: Incremental cost, I see.

30 MR. GILBERT: That is right. It is an old



1 story which comes up in marketing, you have 25% overhead,
2 therefore you can't have a 10% profit because you are
3 losing 15%. I can prove it, even if you have to take it
4 if it is incremental, as you say.

5 MR. MACLEOD: Do you feel that the promotional
6 expenditures of the industry as a whole in Canada
7 serve a useful purpose and are worth what they cost?

8 MR. GILBERT: To the manufacturer, yes.

9 MR. MACLEOD: What about serving a useful
10 purpose - when you say to the manufacturer, you mean it
11 increases his returns?

12 MR. GILBERT: He gets a higher price for
13 his product. He gets the product sold. The important
14 thing is to sell the product.

15 MR. MACLEOD: Do you feel that serves a
16 useful purpose from the point of view of informing doctors?

17 MR. GILBERT: That is a moot question,
18 sometimes it is useful, sometimes detrimental. It
19 depends on the policy of the particular company and how
20 they are trying to sell their product.

21 MR. MACLEOD: Taking it from a slightly
22 different angle, it has been suggested that if this
23 flow of information was shut off it would harm the
24 doctors' knowledge.

25 MR. GILBERT: I think it would be a very
26 good thing.

27 MR. MACLEOD: You think it would help the
28 doctor?

29 MR. GILBERT: To diagnose and to use - the
30 information is always available in the literature which



1 he should be reading and on which he should base his
2 practice concerning drugs, not on the basis of a manufac-
3 turer's literature. I think when a man is dealing with
4 medicine and dangerous drugs, he shouldn't have one
5 slanted point of view.

6 MR. MACLEOD: In your opinion commercially
7 it is sound and from other aspects, undesirable?

8 MR. GILBERT: To the manufacturer it is
9 very sound. I mean those men aren't stupid. They are
10 making profits for so doing and it is proven it is commer-
2 11 cially sound. From the point of view of utility and
12 best medical practice, if it is directed on that purpose,
13 on that basis, I would say it is unsound and dangerous.

14 MR. MACLEOD: Do you feel that promotional
15 costs are a large factor in the present prices charged
16 for brand name drugs?

17 MR. GILBERT: I don't think there is any
18 relationship to it. I think prices are set on the basis
19 of what the market and the conditions will bear and what
20 they can get from the public. I know promotional costs
21 are expressed as percentages. I think to a large extent
22 promotional costs are designed to put them under the
23 15 to 17% profit after taxes. Legislation against the
24 drug companies would be heavy.

25 MR. MACLEOD: Are you suggesting that they
26 deliberately lower their profits by spending large sums
27 on promotion?

28 MR. GILBERT: I am suggesting that.

29 THE CHAIRMAN: You would think this
30 increased promotion would increase sales and therefore



1 increase profits. You suggested this promotion does make
2 larger sales and make profits for them. Wouldn't more
3 promotion have a similar effect or do you think they have
4 gone beyond the point of maximum return?

5 MR. GILBERT: I think these people are
6 businessmen and I think they try to work on an intelligent
7 basis. I give them every credit.

8 THE CHAIRMAN: They are not really spending
9 more money for less return deliberately?

10 MR. GILBERT: To a certain extent - they go
11 into certain expenditures, unwarranted expenditures to
12 reduce their profits.

13 THE CHAIRMAN: Do you think they do it
14 deliberately?

15 MR. GILBERT: They would have 25% profit
16 after taxes, and they could on some of the drugs that they
17 sell, then you would really have an incentive to work on
18 them.

19 MR. MACLEOD: I think that is all I have.
20 I think, perhaps, it is desirable because my questioning
21 has been rather extensive to say that Mr. Gilbert very
22 kindly came here today to answer any questions. He
23 wasn't called as my witness or the Commission's witness.
24 My questions have simply been directed to bring out his
25 opinions on various matters I thought were relevant. I
26 merely point that out because of what I regard as a
27 rather unfortunate interpretation of some of my questions
28 to earlier witnesses.

29 THE CHAIRMAN: Mr. Gilbert only had a short
30 statement and he said he would like to be asked questions.



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1 Have you some questions, Mr. Frawley?

2 MR. FRAWLEY: Mr. Gilbert, Mr. MacLeod has
3 pretty well straightened up the confusion we had with
4 regard to your price list. I want to put it beyond any
5 doubt and ask you a couple of things about it. You have
6 a price here of Achromycin tablets, Lederle's, of \$42.08
7 a hundred. That is on page 25.

8 THE CHAIRMAN: Page 25?

9 MR. FRAWLEY: Page 25, sir. You have
10 explained today, to Mr. MacLeod, that your prices under
11 the column "Brand name drugs at professional prices" are
12 the list prices less 25%.

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1 MR. GILBERT: Correct.

2 MR. FRAWLEY: And the \$42.08 is your cost,
3 as I understand it at the time this issue of Surgical
4 News was published, you were using the list prices prior
5 to some recent changes that had been made. I find that
6 if you use the 25% discount for Achromycin capsules, it
7 brings you back to a list price of about \$56.61 which
8 was the list price.

9 MR. GILBERT: It is \$56.10, I believe.

10 MR. FRAWLEY: And that is the explanation
11 for the discrepancy between that price because yours is
12 a 25% discount off the list, but today then your price,
13 if you are taking 25% off list, your price today --

14 MR. GILBERT: Would be lower.

15 MR. FRAWLEY: Should be or is about \$35.90.

16 MR. GILBERT: It would be on that basis.

17 MR. FRAWLEY: It would be \$42.08?

18 MR. GILBERT: Correct.

19 MR. FRAWLEY: There was a little confusion
20 also arose because we referred to the Starkman catalogue
21 which shows a list for the same product, "Achromycin
22 capsules Lederle of \$28.73" and the advertisement indicates
23 that there is a doctor's discount of 40%. The arithmetic
24 indicates that using a 40% discount and taking Starkman's
25 \$28.73 brings you precisely back to today's list, namely,
26 \$47.88 for Achromycin capsules.

27 All right, so much for that, and that runs
28 through the piece.

29 MR. GILBERT: Correct.

30 MR. FRAWLEY: I also had some difficulty in



1 getting two or three witnesses to accept a suggestion from
2 me that what you show in the opposite column to the brand
3 name, namely "Proper name drugs, properly priced, properly
4 prepared," those are your generic products, or, as you
5 told Mr. MacLeod, you prefer to the word "generic" not
6 to use that, but to use "proper name"?

7 MR. GILBERT: "Proper name".

8 MR. FRAWLEY: That is the same thing that
9 we have been using around this table as "generic"?

10 MR. GILBERT: That is right.

11 MR. FRAWLEY: Is your Declacycline hydro-
12 chloride capsule a generic equivalent of Achromycin
13 capsules, both being 250 mgm dosage?

14 MR. GILBERT: Yes.

15 MR. FRAWLEY: There is not any doubt about
16 that in your mind?

17 MR. GILBERT: None at all.

18 MR. FRAWLEY: Whatever doubt there may have
19 been in the minds of some of the other witnesses. Why
20 do you say that?

21 MR. GILBERT: Achromycin capsules, if you
22 look at the label, is simply a brand of Declacycline
23 hydrochloride.

24 MR. FRAWLEY: Just turning to another one,
25 is your Prednisone tablets on page 29, 2.5 mgm dosage,
26 a generic equivalent for Meticorten tablets, 2.5 mgm?

27 MR. GILBERT: Correct.

28 MR. FRAWLEY: And again, why do you say it
29 is a generic equivalent?

30 MR. GILBERT: Because Meticorten is labelled



1 as a brand of Prednisone.

2 MR. FRAWLEY: I will ask you just one more,
3 on page 27 ---

4 MR. GILBERT: Might I interpose at this
5 point? The governing name is not the brand name. The
6 brand name does not mean anything. It is the proper name
7 or the generic name which controls the contents within
8 the bottle.

9 MR. FRAWLEY: Yes. In other words Decadron
10 that we have been talking a lot about is Dexamethasone?

11 MR. GILBERT: Correct.

12 MR. FRAWLEY: As appears from the literature
13 which accompanies the original package. That brings me
14 to something else that intrigues me very much.

15 In the price list published by the Canadian
16 Pharmaceutical Journal there are some generics listed and
17 prices. I may not have found them all, but I found tetracycline
18 at page 195, 250 mg and then follows the letters,
19 "Emp.", which I take to be "Empire", so that would be
20 Empire's tetracycline, 250 mg at a price of \$29.00 a hundred
21 and that is a generic name drug as far as you understand
22 it, Mr. Gilbert?

23 MR. GILBERT: Yes sir.

24 MR. FRAWLEY: Then, I find Prednisone and
25 I find different suppliers of Prednisone. I find Prednisone
26 E Marion. What is that?

27 MR. GILBERT: Elliot Marion I believe that
28 is a Quebec company.

29 MR. FRAWLEY: And I find Prednisone Intra,
30 what is that?



1 MR. GILBERT: Intra medical, I think.
2 MR. FRAWLEY: And I find Prednisone Maney.
3 Those are listings for Prednisone which is a generic name
4 drug. Then as I only have one more, Prednisolone, without
5 giving you any further particulars, that is a generic name
6 drug again. I may be wrong, because I don't have much to
7 guide me and therefore I should not say there are no other
8 generics named in that book. I won't say that, but as I
9 look for some special ones, I find them missing.

10 For instance, I don't find Triamcinolone
11 listed in this particular book under its proper name.
12 Would you expect to find it in this price book?

13 MR. GILBERT: I have not studied the subject
14 of Triamcinolone, but I could hazard a guess as to why.

15 MR. FRAWLEY: You could hazard a guess as
16 to why?

17 MR. GILBERT: Yes.

18 MR. FRAWLEY: Why?

19 MR. GILBERT: We could not find Triamcinolone
20 and Dexamethasone offered for sale by those names in
21 Canada.

22 THE CHAIRMAN: Not just a guess. Don't
23 guess.

24 MR. GILBERT: I will assume if these are
25 considered new drugs, then they can't be marketed by any
26 company until they have processed a food and drug applica-
27 tion which is a long, lengthy, tedious and expensive
28 process and takes time to do.

29 MR. FRAWLEY: My first question is, is
30 Triamcinolone available for purchase somewhere in the



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1 world?

2 MR. GILBERT: Yes.

3 MR. FRAWLEY: By its generic name of
4 Triamcinolone?

5 MR. GILBERT: Yes.

6 MR. FRAWLEY: Is Dexamethasone available to
7 be purchased somewhere in the world?

8 MR. GILBERT: Yes.

9 MR. FRAWLEY: But it is not available in
10 Canada?

11 MR. GILBERT: Not available for sale in
12 Canada.

13 MR. FRAWLEY: Not available for sale in
14 Canada?

15 MR. GILBERT: No.

16 MR. FRAWLEY: Could it be brought into
17 Canada?

18 MR. GILBERT: Yes.

19 MR. FRAWLEY: Could you or anyone else?

20 MR. GILBERT: I mean to process an export
21 order for Dexamethasone shortly.

22 MR. FRAWLEY: What is that, sir?

23 MR. GILBERT: I mean to process an export
24 order for Dexamethasone shortly.

25 MR. FRAWLEY: There would not be any
26 difficulty first in finding it or bringing it to Canada,
27 entering it through customs and putting it in your ware-
28 house?

29 MR. GILBERT: Very simple.

30 MR. FRAWLEY: But there would be another



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1 difficulty and I would like you to explain what that other
2 difficulty is which would make it difficult for you to
3 offer for sale in Canada Dexamethasone just as you are
4 offering, for instance, chloramphenicol.

5 MR. GILBERT: The Standard Food and Drug
6 Act, as I understand it, is that any products which are
7 not in an official Compendium like the British Pharmacopoeia,
8 the U.S.P. or the N.S. are considered as new drugs and
9 in order to be able to sell that particular drug, you
10 would have to process the full application covering the
11 methods of manufacture, the controls that are used during
12 the manufacture, the controls that you have in your own
13 plant with respect to the finished product, full label
14 control, full description of the ingredients used in
15 compounding, you would have to supply toxicity tests,
16 clinical tests and then maybe you will get the application
17 approved.

18 At this point I would like to say that
19 the next big bottleneck in the drug industry is going to
20 be the Food and Drug Act after the Patent Act. This is
21 what will maintain high drug prices for a long time to
22 come.

23 MR. FRAWLEY: Well, Mr. Gilbert, I make no
24 apologies for the position I take. I was instructed by
25 the Government of Alberta there should be more and more
26 generics available to the public. They are all procurable
27 somewhere in the world.

28 MR. GILBERT: Definitely.

29 MR. FRAWLEY: Did you say it is difficult
30 to get the approval which first must be obtained from the



1 Food and Drug Administration in Ottawa?

2 MR. GILBERT: Correct.

3 MR. FRAWLEY: And if you are able to buy

4 Dexamethasone or Triamcinolone from some Italian manufacturer
5 or Danish manufacturer or Swiss manufacturer, could it
6 not be passed upon as being a pure product?

7 MR. GILBERT: I think so, definitely.

8 MR. FRAWLEY: What are the difficulties of
9 the Food and Drug Administration in Ottawa that would make
10 it difficult for you to get their approval?

11 MR. GILBERT: I will go back to what I
12 said earlier. The Canadian situation is not bad as yet.
13 In the United States you could not even get approval on
14 a product which has been approved. We have been working
15 for one year trying to get an approval on a product called
16 "Meprobamate" on which we have the process and everything.
17 There are continual bottlenecks thrown, inconsequential
18 bottlenecks, and we have sold millions of bottles in Canada.

19 MR. FRAWLEY: You say you cannot sell
20 Meprobamate in Canada?

21 MR. GILBERT: Yes, you can sell it in Canada
22 but not in the United States unless you have a Food and
23 Drug approval and I fear that ultimately we might even have
24 this situation in Canada. As it is, I think you will find
25 that in the United States in a few years all new products
26 will be primarily protected against marketing in generic
27 or proper name for years after the product is available on
28 the market by the drug manufacturers.

29 MR. FRAWLEY: You say Empire markets tetra-
30 cycline as such and the C.Ph.A. Journal lists it as such.



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1 Did Empire have any trouble getting Tetracycline, this
2 product that is listed here on page 195, through the
3 Food and Drug Administration?

4 MR. GILBERT: It didn't have to because this
5 product is an official product. It is not considered a
6 new product in Canada because it is described in the British
7 Pharmacopoeia and the United States Pharmacopoeia.

8 MR. FRAWLEY: It is getting the new drugs
9 through the Food and Drug Administration that you say is
10 difficult?

11 MR. GILBERT: That is right.

12 MR. FRAWLEY: Would you expect that if
13 Dexamethasone, called Dexamethasone today, marketed in
14 Canada as such, that you could buy it cheaper than Merck's
15 price of \$9.40 for 30?

16 MR. GILBERT: I have offered it in export
17 at \$35.00 a thousand.

18 MR. FRAWLEY: Merck's listed price is
19 \$29.80 in hundred. All right, so much for that.

20 MR. GILBERT: I will add that at \$35.00,
21 I making a good profit.

22 MR. FRAWLEY: There are a good many of the
23 psychiatric drugs which are not available by their generic
24 names. Is Largactil, Chlorpromazine, is that available?

25 MR. GILBERT: That is available.

26 MR. FRAWLEY: Why is that available?

27 MR. GILBERT: It is a U.S.P. product.

28 MR. FRAWLEY: Pro-Tran is Promazine
29 Hydrochloride, is it available generically?

30 MR. GILBERT: Yes.



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1 MR. FRAWLEY: For the same reason?

2 MR. GILBERT: Yes.

3 MR. FRAWLEY: Trilafon, is Perphenazine,
4 is that available generically?

5 MR. GILBERT: I would say offhand that it
6 is not.

7 MR. FRAWLEY: Stelazine, which is
8 Triflupromazine Dihydrochloride, is it available generically?

9 MR. GILBERT: No. When you say "available",
10 do you mean available to Canadian consumers?

11 MR. FRAWLEY: Available the way that Tetra-
12 cycline is available, marketed by Empire in that book.

13 MR. GILBERT: Yes.

14 MR. FRAWLEY: So coming to your own company,
15 the way that Tolbutamide is marketed for you in its
16 generic name --

17 MR. GILBERT: The answer stands.

18 MR. FRAWLEY: Is Tolbutamide a generic
19 equivalent of Orinase tablets?

20 MR. GILBERT: Orinase is the brand name or
21 Mobenal, are two brand name products.

22 MR. FRAWLEY: Two different companies?

23 MR. GILBERT: Right.

24 MR. FRAWLEY: Orinase is made by Hoechst
25 Company?

26 MR. GILBERT: Right.

27 MR. FRAWLEY: Have you overcome the hurdle
28 of the Food and Drug Administration on Tolbutamide?

29 MR. GILBERT: No difficulty there.

30 MR. FRAWLEY: Because it is a U.S.P. product?



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1 MR. GILBERT: Correct, I believe it is.

2 MR. FRAWLEY: I have only a few more to
3 ask you. Sandez's Mellaryl is Thieridazine.

4 MR. GILBERT: That would be considered a
5 new drug, too.

6 MR. FRAWLEY: It is what?

7 MR. GILBERT: A new drug.

8 MR. FRAWLEY: It is a new drug and there
9 would be a difficulty with the Food and Drug people in
10 Ottawa?

11 MR. GILBERT: Right.

12 MR. FRAWLEY: And Squibb's Vesprin is
13 Triflupromazine Hydrochloride. Is it available to be
14 bought generically by you or anybody?

15 MR. GILBERT: Yes, I believe it is also
16 new.

17 MR. FRAWLEY: And for that reason not
18 available?

19 MR. GILBERT: That is right.

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MR. FRAWLEY: Equanil, Wyeth's Equanil is meprobamate?

MR. GILBERT: That is a U.S.P. product and is available.

THE CHAIRMAN: What is it you are trying to establish, Mr. Frawley? Are these products for which you are quoting trade names of a number of manufacturers, are they available under those trade names but not available under the proper names?

MR. FRAWLEY: They are certainly available under the trade names, and you pay brand name price, and I want to know if they are available generically or if they are -- I want to get a broad idea what the difficulties are about getting generics on the market.

THE CHAIRMAN: That raises a question in my mind how a trade name drug becomes available if it is necessary to have the drug approved.

MR. FRAWLEY: Yes, because you see what is running in my mind ---

THE CHAIRMAN: It must be approved as a generic product.

MR. FRAWLEY: Yes, because you see Wyeth's Equanil is meprobamate; that meprobamate must be on Wyeth's bottle of Equanil.

THE CHAIRMAN: How does it get marketed under the trade name if the proper name has not been approved?

MR. FRAWLEY: That is true, but you see, just taking Equanil, and Mr. Gilbert will probably know about this, Wyeth's brand of meprobamate is Equanil; is



1 that right?

2 MR. GILBERT: Right.

3 MR. FRAWLEY: And every bottle, every ori-
4 ginal package of that product would have the word "mepro-
5 bamate" under it, I take it?

6 MR. GILBERT: Equanil, brand of meprobamate.

7 MR. FRAWLEY: Now, that being so, what is
8 the difficulty? Why can't you market it as meprobamate?
9 It is meprobamate.

10 MR. GILBERT: Well, we are marketing it as
11 meprobamate.

12 MR. FRAWLEY: Let me take another one that
13 you can't. Let me give you an example ---

14 MR. GILBERT: Take dexamethasone.

15 MR. FRAWLEY: If Merck's or U.S.P. Decadron
16 is simply Merck's brand of dexamethasone, which you say
17 is what it is ---

18 MR. GILBERT: Right.

19 MR. FRAWLEY: It is Merck's brand of dexa-
20 methasone that appears on the original package?

21 MR. GILBERT: Yes. It is not available
22 under the generic name.

23 MR. FRAWLEY: But it is available. It is
24 available as Decadron and it is dexamethasone?

25 MR. GILBERT: That is right.

26 MR. FRAWLEY: Why can't it be sold as dexa-
27 methasone?

28 MR. GILBERT: They could sell it as dexa-
29 methasone if they want to, but only Merck can do that.

30 MR. FRAWLEY: That is right. Only Merck.



1 He can sell it as either Decadron, the name that he has
2 established, or he can sell it as dexamethasone?

3 MR. GILBERT: That is correct.

4 MR. FRAWLEY: And if dexamethasone is the
5 generic name, the proper name, why couldn't you or Empire
6 or anyone else that specializes in generics sell it and
7 call it dexamethasone?

8 MR. GILBERT: The Food and Drugs Act takes
9 care of that.

10 MR. FRAWLEY: You wouldn't be selling it as
11 Merck's brand of dexamethasone.

12 MR. GILBERT: It is the intrinsic drug
13 itself, dexamethasone, which is being approved for sale.
14 Regardless of what Merck calls it, in order to sell dexa-
15 methasone you must have approval from the Food and Drug
16 as an illustration.

17 THE CHAIRMAN: You must have approval of your
18 preparation?

19 MR. GILBERT: If I wanted to market it I
20 must have approval from the Food and Drug administration.

21 THE CHAIRMAN: Not of dexamethasone but of
22 your preparation of dexamethasone?

23 MR. GILBERT: I would probably market it
24 under the name of dexamethasone.

25 THE CHAIRMAN: What you are getting is
26 approval of your preparation of it?

27 MR. GILBERT: Yes.

28 MR. FRAWLEY: Let me understand. You say
29 Merck has already been through the procedure of the Food
30 and Drug people in Ottawa?



1 MR. GILBERT: I would assume so because
2 they are marketing it.

3 MR. FRAWLEY: Let's assume that. What the
4 Food and Drug people were satisfying themselves about was
5 dexamethasone; they were not approving a name?

6 MR. GILBERT: Yes.

7 MR. FRAWLEY: They were not approving a
8 drug?

9 MR. GILBERT: The intrinsic product itself.
10 The product itself.

11 MR. FRAWLEY: Well, if that is what they
12 were approving, why isn't it available for people to sell?
13 If you sold it as Decadron you would be infringing the
14 name ---

15 MR. GILBERT: I could do this, but I will
16 predict what will happen the first time I market it, the
17 Food and Drug will swoop into my plant and appropriate
18 everything I have and perhaps fine me.

19 MR. FRAWLEY: They might. I don't want or
20 intend to be outrageous about it. I am having difficulty
21 understanding, and it may be very simple to some people.
22 They would swoop down on you perhaps to satisfy them-
23 selves your dexamethasone that you are selling, calling
24 it dexamethasone, was really dexamethasone?

25 MR. GILBERT: No. The mere sale of it.

26 THE CHAIRMAN: It would be on the ground
27 that you were selling it without having it approved?

28 MR. GILBERT: That is right. It is classed
29 as a new drug, and this is the coming thing in the drug
30 industry which will maintain high prices.



1 MR. FRAWLEY: Dexamethasone has necessarily
2 been approved?

3 MR. GILBERT: For Merck and Company.

4 MR. FRAWLEY: Yes, but it is still dexametha-
5 sone?

6 MR. GILBERT: Yes. C'est la vie.

7 MR. MACLEOD: Mr. Gilbert, if I may interrupt,
8 the situation then is different once a drug is approved
9 in one of the official books? That is the key to the
10 thing?

11 MR. GILBERT: That is right. That is my
12 understanding of it. Now, it may change overnight.

13 MR. MACLEOD: Any drug that is listed in
14 the official books you may sell without making a new pro-
15 duct presentation?

16 MR. GILBERT: That is right.

17 MR. MACLEOD: But if it is not listed in the
18 official book, you have to make a new product presentation?

19 MR. GILBERT: That is right.

20 MR. MACLEOD: That is the difference?

21 MR. GILBERT: Yes.

22 MR. FRAWLEY: I would think from the whole
23 tenor of your price list in your Surgical News that the
24 individual and the market to whom you make the appeal is
25 the doctor and the hospital rather than the retail pharma-
26 cist?

27 MR. GILBERT: We have made attempts with
28 the retail pharmacists too.

29 MR. FRAWLEY: Why is it you are making a
30 special appeal to the physician?



1 MR. GILBERT: Well, actually the druggist
2 is not a salesman of a product. He fills orders which he
3 receives and is supposed to fill it in the way it is
4 written. Unless he has the privilege of selecting the
5 product by an unspecified generic name, he has to provide
6 the product which is called for.

7 Therefore, if we are going to get our pro-
8 ducts used, it will have to be on the basis of the physi-
9 cian wanting to use this product.

10 MR. FRAWLEY: So that you are endeavouring
11 to present your product and indicate to the physicians
12 the availability of your products by their generic names
2 so that they will prescribe them by the generic name?

14 MR. GILBERT: Right. Preferably specifying
15 "Gilbert", which is our attitude.

16 MR. FRAWLEY: Thank you very much.

17 MR. CARIGNAN: Mr. Gilbert, do you know when
18 a new drug ceases to be a new drug?

19 MR. GILBERT: My understanding is when it
20 appears in the official Compendium. Now, that is not so
21 in the United States.

22 MR. CARIGNAN: What length of time does it
23 require usually?

24 MR. GILBERT: Well, a lot depends on when a
25 new issue comes out. Sometimes they put an issue out -
26 U.S.P., for instance, comes out every ten years, but there
27 may be supplements which come out in between, and these
28 are added to the U.S.P.

29 However, I think you can safely say that a
30 product won't really be official for five to seven years



1 after its issue.

2 MR. FRAWLEY: Just one more question before
3 Mr. Turnbull starts, just answering your question, I
4 find in the literature which accompanies Decadron, the
5 notation "Decadron is the trademark of Merck and Company
6 Limited for dexamethasone".

7 MR. TURNBULL: Mr. Gilbert, my name is
8 Turnbull of the Canadian Pharmaceutical Association. I
9 do not have a copy of your presentation this afternoon.
10 Transportation made me a little late in arriving, and I
11 arrived only to hear my name mentioned in conjunction
12 with the name of another gentleman, or a gentleman.

13 MR. FRAWLEY: "The other gentleman" is
14 quite all right.

15 MR. TURNBULL: I was using the term rather
16 loosely, sir. I don't know whether you wish to discuss
17 this now, and I think possibly it might be wise either
18 now or shall we say tomorrow morning when the Commission
19 will reconvene, but there are one or two things that have
20 come to my mind that I would like a little clarification
21 on in your presentation this afternoon, which I have
22 followed with extreme interest. You mentioned in one
23 part of your presentation, when you were discussing your
24 catalogues and the discount figures which you allow from
25 them, you mentioned the possibility of certain hidden
26 discount arrangements other than those which you actually
27 published.

28 Did I hear that correctly?

29 MR. GILBERT: I didn't say discount arrange-
30 ments. There might be other hidden arrangements.



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1 MR.TURNBULL: Other hidden arrangements?

2 MR. GILBERT: In other words, you might
3 tender on a particular drug on a competitive basis which
4 would possibly have no relation to your official selling
5 price.

6 MR. TURNBULL: But these arrangements are
7 not available to, shall we say, all retailers who may
8 wish to buy your products?

9 MR. GILBERT: We try to maintain a set policy
10 on sales.

11 MR. TURNBULL: With no special arrangements
12 being available to them?

13 MR.GILBERT: That is right.

14 MR. TURNBULL: And no individual retail
15 pharmacist or any group of individual retail pharmacists
16 could obtain special hidden arrangements from you?

17 MR. GILBERT: I think it is going on in the
18 field all the time.

19 MR. TURNBULL: But they could not obtain
20 them from you?

21 MR. GILBERT: I didn't say that. In other
22 words, we will meet competition.

23 MR. TURNBULL: Earlier I believe you sugges-
24 ted you were having difficulty getting wholesalers to stock
25 your items. I presume that has been answered in a later
26 part of the submission relative to your promotions to the
27 doctor instead of the retail pharmacist, and the reason
28 for promoting to the physician rather than the pharmacist
29 was to get him to write "Gilbert", and so far there has
30 been no demand built up - presumably no relatively high



1 demand built up?

2 MR. GILBERT: That is right.

3 MR. TURNBULL: To the point where the whole-
4 salers were prepared to carry ---

5 MR. GILBERT: We do get drug shipments.

6 MR. TURNBULL: That is the reason? It is
7 not anything else from an economic basis?

8 MR. GILBERT: Well, I think their stand
9 basically is against the encroachment of the generic
10 drug. In other words, they would not make it easy for a
11 generic drug manufacturer to get in.

12 MR. TURNBULL: As you know, the price book
13 of drugstore merchandise to which Mr. Frawley has referred
14 as being published by the Canadian Pharmaceutical Journal
15 - I shouldn't say "as you know", you possibly don't know -
16 but I will tell you the price book is compiled in a very
17 inexpensive way through the courtesy of Drug Trading
18 Company permitting us to obtain this information from
19 their I.B.M. cards, and the only cost to us is the over-
20 time of half-a-dozen employees who pull these cards and
21 what-not. In other words, they have been even able to
22 sell this for \$6 and even able to make a reasonable profit.

23 MR. GILBERT: And I think it is a very
24 valuable service, too.

25 MR. TURNBULL: As Mr. Frawley pointed out,
26 there are certain generic names in here. Do you sub-
27 scribe to the theory that brand names are expensive; that
28 is, purchasing by brand names is expensive?

29 MR. GILBERT: I would say that it controls
30 the price of a drug and prevents the free choice of the



1 purchasing agent or the purchaser, who is the consumer.
2 In other words, it prevents them from shopping a product
3 on the basis of its intrinsic merit to get the best
4 available price.

5 MR. TURNBULL: Don't misunderstand me. I
6 am not waving the flag for the brand name manufacturer,
7 but I was just wondering about this because it has come
8 up in conversations before the Commission from time to
9 time that there is a basic theory that because of the
10 very fact a brand name exists, it is expensive.

11 MR. GILBERT: I think it is a case in prac-
12 tice. It is actual fact, but it does not have to be so.

13 MR. TURNBULL: Do you sell any brand name
14 products which you yourself manufacture, sir?

15 MR. GILBERT: Yes.

16 MR. TURNBULL: A little later on during
17 your discussion with Mr. MacLeod you made mention of some
18 of the difficulties that you had had in quality from some
19 of the finished products purchased in foreign lands. Some
20 of these were - you didn't comment on the quality, but on
21 the physical attributes.

22 MR. GILBERT: Pharmaceutical elegance is
23 what I referred to.

24 MR. TURNBULL: I believe that this has caused
25 you certain problems from time to time?

26 MR. GILBERT: That is right.

27

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MR/hm
1 MR. TURNBULL: This does not occur you
2 indicated, or did you that this does not occur any longer
3 in any of your drug preparations?

4 MR. GILBERT: It would be dishonest for me
5 to say it does not occur. When you are making millions
6 of tablets and capsules, something is going to slip
7 through but if you take it on a percentage basis I say
8 that virtually it does not occur. It is negligible.

9 MR. TURNBULL: In your letter to the
10 Calgary Hospital you made mention, I believe, in there
11 that your products are frequently sampled by the Food
12 and Drug Directorate and tested by the Food and Drug
13 Directorate, and what have you. Such sampling takes place
14 relative to the products of all manufacturers?

15 MR. GILBERT: That is right.

16 MR. TURNBULL: More or less.

17 MR. GILBERT: That is right. I mean that
18 is a practise of the Food and Drug.

19 MR. TURNBULL: Is it permissible under the
20 Food and Drug regulations, and what not, to lay any claim
21 to quality based on the fact that such sampling and test-
22 ing has taken place?

23 MR. GILBERT: No.

24 MR. TURNBULL: No, I didn't think it was.
25 Later you made mention that there has been some difficulty,
26 that you have experienced some difficulty in buying
27 overseas, with companies of poor reputation. Can you give
28 us what establishes or how you came to know or just what
29 that poor reputation is, what it relates to? In other
30 words, how does a company get a poor reputation in a



1 pharmaceutical field?

2 MR. GILBERT: Well I couldn't name any
3 specific companies but if a company once or twice produces
4 a product which does not meet standards of testing, I
5 would imagine that company would have a poor reputation.

6 MR. TURNBULL: This is on any individual
7 tests or possibly more tests?

8 MR. GILBERT: That is right. In other words,
9 if you have trouble with a company you would generally
10 steer away from this company.

11 MR. TURNBULL: This news just gradually
12 circulates?

13 MR. GILBERT: I wouldn't say that. I mean
14 I could not name any specific companies. There are many
15 ways in which drugs are procured. You very often don't
16 even know the origin of the manufacturer of the drug
17 because there are many brokerage houses who handle these
18 drugs from various sources. Very often you buy this from
19 a broker.

20 MR. TURNBULL: I was very interested to hear
21 Mr. Gilbert your discussion of selling on the foreign
22 market. I think this is a very interesting thing and I
23 was interested to hear your comments concerning overhead
24 costs and contributory profits and this type of thing. I
25 believe that you mentioned that selling on a 10% profit
26 meant a 15% less but really doesn't, type of thing. I
27 made this statement, and I don't want you to necessarily
28 agree with me but Mr. Frawley and I had a little difficulty
29 in establishing a common area of agreement this morning,
30 that very often tendered prices, and I am quoting from the



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1 brief of the Canadian Pharmaceutical Association on the
2 lower part of page 50:

3 "Very often, as a result of the above,
4 tendered prices of a manufacturer will be
5 determined on the basis of a variable cost
6 plus a slight excess which may be applied
7 to reducing overhead. He makes a contributory
8 profit in that he receives an amount in
9 excess of his variable cost, but he may not
10 realize a clear profit on such sales."

11 We were discussing sales to institutions and governments,
12 and this type of thing.

13 MR. GILBERT: You lost me slightly.

14 MR. TURNBULL: I hope I didn't lose you too
15 badly because I would like you to either confirm or say
16 that that is nonsense.

17 MR. GILBERT: I beg you to read it again,
18 slowly.

19 (Mr. Turnbull reads quote from bottom of page again).

20 MR. GILBERT: I think Mr. Smith has explained
21 that very nicely when he said when you construe that type
22 of business as an increment to the normal running of the
23 business.

24 THE CHAIRMAN: If that is what you were
25 talking about, I think the witness is in agreement with
26 your statement.

27 MR. TURNBULL: Yes, I just wanted to establish
28 that sir.

29 THE CHAIRMAN: I think the argument this
30 morning was not so much whether that may happen, but



1 whether you knew it did happen?

2 MR. TURNBULL: That is right. This was
3 based on my knowledge. I wanted Mr. Gilbert to confirm
4 my knowledge.

5 MR. FRAWLEY: I would put a question mark
6 after knowledge on your own statement.

7 MR. TURNBULL: Mr. Chairman, it is twenty
8 to five. I do have one or two other questions if I may.

9 THE CHAIRMAN: Mr. Gilbert is here this
10 afternoon. If it is only a matter of one or two questions I
11 think you should try to finish. If it is going to be quite
12 a while ---

13 MR. TURNBULL: No sir, I would merely ask Mr.
14 Gilbert if he cared to explain the second last paragraph
15 of this afternoon's presentation to the Commission. I
16 don't mind anybody questioning my knowledge but I do mind
17 anybody pointing the finger at my integrity and if that
18 enters in this, I think possibly it should be brought out
19 because I might have misled the Commission for the past
20 two or three days as to the presentation that I have been
21 privileged to present.

22 MR. GILBERT: I see nothing questioning
23 your integrity Mr. Turnbull.

24 MR. TURNBULL: Thank you very much. Mr.
25 Gilbert and I met several years ago and I had the pleasure
26 of getting to know him and when he requested a visit to
27 my office, it was my first occasion and we have met on
28 many other occasions Mr. Chairman and I can only say that
29 I am very, very pleased that he saw fit to come before
30 this Commission. I have enjoyed hearing his comments.



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1 There were one or two other things that I wanted to bring
2 to your attention. I knew that he is an extremely busy
3 man and that his appearance today has added very much.

4 I would also like it to be known that I
5 and many others who appeared before this Commission spent
6 many weeks and months, and quite a few sleepless nights
7 preparing our presentation to the Commission voluntarily,
8 sir.

9 THE CHAIRMAN: I don't think we have
10 questioned that. If there are no further questions, thank
11 you Mr. Gilbert. We have spent a longer afternoon than
12 we anticipated. Questions often lead us a lot further
13 than you think when you start. We will adjourn until ten
14 o'clock tomorrow morning and the College of Pharmacy will
15 be here tomorrow morning.

16 MR. FRAWLEY: And that is the only witness,
17 is it?

18 THE CHAIRMAN: The only one that I know of
19 unless somebody turns up that we don't expect.

20
21 ---Whereupon the hearing adjourned until 10 a.m.,
22 Friday, October 27th, 1961.

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3 INQUIRY UNDER SECTION 2

4 OF THE COMBINES INVESTIGATION ACT

5

6 Relating to the manufacture, distribution and sale
7 of drugs

8

9

By Director of Investigation and Research

10

Combines Investigation Act

11

12

COMMISSION:

13

C. RHODES SMITH, Q.C. -- Chairman

14

A.S. WHITELEY, M.A. Member of the
Commission

15

PIERRE CARIGNAN, Q.C. Member of the
Commission

16

F.N. MACLEOD Combines Officer,
representing the Director of Investigation
and Research

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Proceedings of hearings commencing at
10 a.m., Thursday, October 27th, 1961,
et seq in the City of Toronto, in the
Province of Ontario.

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Toronto, Ontario.
October 27th, 1961.

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3 ---On commencing at 10.00 a.m.

4 THE CHAIRMAN: This morning we are to hear
5 a brief from the Ontario College of Pharmacy. Mr. Isbister?

6 MR. ISBISTER: Mr. Chairman, my name is
7 Isbister, Phillip Isbister. I appear for the Ontario
8 College of Pharmacy. With me, sir, this morning is Mr.
9 George G. Caldwell, who is president of the Council of
10 the College of Pharmacy. Also with me is Mr. P. T. Moisley,
11 registrar, treasurer of the College and Mr. W. Isaacson
12 who is a member of Council and Chairman, until last week
13 of the Prescription Pricing Committee. He was chairman
14 for some four years. It occurred to us he might be able
15 to shed some light on the aspects of pharmacy that this
16 Commission might be interested in. Now, sir, I had in
17 mind as to the brief -- I furnished Mr. MacLeod with
18 copies and the Commission have them before them. Mr.
19 Moisley as registrar-treasurer is a full-time administrative
20 officer and senior administrative officer of the College.
21 Mr. Caldwell and Mr. Isaacson are practising pharmacists.
22 Mr. Moisley as registrar-treasurer and senior administrator
23 has had, as you will anticipate much to do with the
24 preparation of the material which is in the brief. With
25 your permission Mr. Moisley will put it to the Commission.
26 Mr. Moisley. I had in mind, I anticipated, I am not too
27 familiar with your practice, that at the conclusion of
28 the formal presentation these gentlemen and myself could
29 answer questions.

30

THE CHAIRMAN: Mr. Moisley will read the



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1 brief. That is our normal practice. He may make any
2 comment he desires to make as he goes along or at the
3 end of it. Possibly we might even interrupt if there is
4 something that seems to call for additional information.

5 MR. ISBISTER: You will perhaps be pleased
6 to see it is not as long as some before you have been.

7 THE CHAIRMAN: Some have taken quite a while.

8 MR. FRAWLEY: It is a good Friday brief.

9 MR. MOISLEY: Mr. Chairman, is there not
10 a lectern like I saw the other day?

11 THE CHAIRMAN: I believe that belonged to
12 the people who brought it.

13 MR. MCISLEY: I see, thank you.

14 MR. ISBISTER: Mr. Moisley, would you
15 proceed.

16 MR. MOISLEY: Mr. Chairman, Members of the
17 Commission.

18 The Ontario College of Pharmacy is a body
19 corporate established by provincial legislation and
20 continues under the Pharmacy Act, Revised Statutes of
21 Ontario, 1960, Chapter 295. It is primarily a licensing
22 body responsible to the Minister of Health of the Province
23 for the enforcement of the Act.

24 Prior to 1871 there were no restrictions
25 on those who wished to operate an apothecary shop in what
26 was then Upper Canada, now the Province of Ontario. No
27 standards of education were in force nor was any examina-
28 tion required to ensure that those who dispensed poisons
29 and other potent substances were qualified so to do.

30 In the absence of legislation, chemists, as



1 pharmacists were then known, met in groups in Ottawa,
2 Toronto and other centres. On June 28, 1867, just two
3 days before Confederation, the Toronto group, known as
4 The Toronto Chemists and Druggists Association, boasted
5 eighteen members and at a meeting on July 10 eight new
6 members were added. During August and September of
7 Confederation year no further members were added but the
8 name of the organization was changed to that of The
9 Canadian Pharmaceutical Society, because of their pre-
10 tensions to a federal status for the profession of pharmacy.
11 By the end of 1867 members numbered fifty-five, representing
12 such Ontario centres as Oshawa, London, Collingwood and
13 Lindsay.

14 Then, in May 1868, the members of the
15 Ottawa organization joined as a group and steps were taken
16 to establish a publication for the Society. The first
17 edition of the Canadian Pharmaceutical Journal appeared in
18 the same month.

19 The Society did investigate the possibility
20 of obtaining federal legislation to regulate the practice
21 of pharmacy, proposing that a Pharmaceutical Board of
22 Canada be appointed and invested with the power to examine
23 the license. However, these attempts to obtain federal
24 legislation were of no avail because of lack of jurisdic-
25 tion under the British North America Act. The Ontario
26 government was then approached with the request that a
27 provincial Pharmacy Act be enacted. Such a bill was
28 introduced in the Legislative Assembly on January 12, 1869,
29 and received its second reading in November of that year.
30 The bill was then referred to Committee, was finally passed



1 on February 6, 1871, and became law.

2 It was during this period that The Canadian
3 Pharmaceutical Society ceased to be known as such and on
4 November 6, 1869, it was resolved that hereafter the
5 organization would be known as the Ontario College of
6 Pharmacy. The Pharmacy Act established the Ontario College
7 of Pharmacy as a body corporate with authority to license
8 pharmacists, to acquire real estate and to establish a
9 School of Pharmacy. Thus did the College originate as
10 the educations, licensing and disciplining body for
11 "Chemists and Druggists" in Ontario. The Pharmacy Act
12 of 1871 specified definite requirements for those who
13 wished to practise pharmacy. It provided that only those
14 who were registered as members of the Ontario College of
15 Pharmacy would be permitted to assume the title of
16 "Chemist and Druggist".

17 Education was one of the earliest considera-
18 tions of the Canadian Pharmaceutical Society and an attempt
19 - unsuccessful due to lack of funds - was made to
20 inaugurate lectures in the fall of 1867. A year later
21 efforts were successful and lectures were given periodically
22 in different locations until the first Council meeting of
23 the Ontario College of Pharmacy in December 1871, which
24 then made arrangements with certain persons and organiza-
25 tions for more comprehensive lectures on a greater number
26 of subjects on an optional basis.

27 One of the earliest aims of the Ontario
28 College of Pharmacy was the development of its own
29 educational facilities and in August 1881 a committee was
30 appointed to study the best means of establishing a



1 teaching college. Recommendations were subsequently
2 received and promptly acted upon with the result that
3 classes began in April 1882 under the leadership of Dean
4 E.B. Shuttleworth.

5 In 1884 the Council began to take steps
6 toward securing permanent premises for the teaching college.
7 Property was finally purchased at the present location,
8 44-46 Gerrard Street East, Toronto, plans were drawn and
9 contracts let, the cornerstone was laid on August 8, 1885,
10 and the building was completed and officially opened on
11 February 3, 1887.

12 In 1884 the Pharmacy Act of 1871 was
13 repealed and replaced by a new statute which established a
14 more rigid standard of apprenticeship. Continued efforts
15 to upgrade pharmaceutical education prevailed. In 1889
16 the Ontario Legislature, on the recommendation of the
17 Council, again revised the Pharmacy Act requiring compulsory
18 attendance at the lectures after matriculation and four
19 years of apprenticeship before candidates might sit for
20 examination.

21 Thus, within twenty-five years after they
22 had first banded together, the pharmacists of Ontario had
23 witnessed their administrative organization expanded to a
24 teaching college.

25 In January 1892 the Senate of the University
26 of Toronto adopted a statute granting the Ontario College
27 of Pharmacy affiliation with the University and conferring
28 the degree of Bachelor of Pharmacy (Phm.B.) on licentiates
29 of the College passing a special examination for the
30 degree.



With development of the academic programme,
more physical accommodation became a necessity and the
original building of 1886 was enlarged in 1891 to include
laboratories. Later, in 1940-41, a large addition of
three stories at an expense of \$135,000.00 was built. A
further addition was made in 1950 to provide more office
and library space.

The early years of the College saw a
continued effort to secure the best available teaching
staff and a constant striving to better pharmaceutical
education. At the turn of the century the Education
Committee began thinking in terms of a two-year course.
Several Districts favoured the move and finally in 1919
the faculty recommended establishing such a course. The
recommendation was adopted by the Council of the College
in 1920. After a period of frustration the necessary
facilities were made available and, through the assumption
by the University of some of the teaching, the
two-year course was established in 1927. It is interesting to note that in 1926, even before the start of
teaching of the two-year course, statements were being
made that a two-year course in pharmacy was inadequate
and did not merit a Bachelor's degree.

In 1937 discussion took place with the
University in respect to extending the course to three
years. In 1939 the necessary building was started but the
war prevented commencement of the new course. Debate
continued on the merit of the three- or-four year course
and finally in November 1944 the four-year course was
adopted. The University of Toronto signified that it



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1 was favourable to the establishment of such a course and
2 stated that it would definitely not grant a Bachelor of
3 Science degree to graduates of a three-year course.

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1 In 1945 a seven-year plan for education was
2 drawn up, including a plan to sponsor the training of
3 staff members with Doctor of Philosophy degrees because
4 it was practically impossible to obtain staff members from
5 other colleges. In 1947 the University of Toronto passed
6 Statute 1845 establishing officially the degree of Bache-
7 lor of Science in Pharmacy. These years also saw further
8 additions to the teaching staff, additions to the building
9 and many curricular changes, until finally in the summer
10 of 1953 the Ontario College of Pharmacy surrendered its
11 teaching function to the University of Toronto. The
12 teaching staff of the College became members of the teaching
13 staff of the newly created Faculty of Pharmacy of the
14 University.

15 The College transferred to the University
16 the title to the buildings and property situate at 44-46
17 Gerrard Street East, made a cash grant of \$50,000.00 and
18 donated a newly equipped dispensing laboratory costing
19 \$25,000.00.

20 It is worthwhile to note that all this was
21 accomplished by the pharmacists of Ontario at their own
22 expense. They also realized that the profession must keep
23 pace with modern scientific progress and that accordingly
24 pharmaceutical education must be the best possible to
25 obtain. To that end the pharmacists of Ontario overwhel-
26 mingly supported this most important move which transferred
27 the teaching function to the University of Toronto.

28 The academic requirements for licensure in
29 Ontario are graduation from the University of Toronto
30 Faculty of Pharmacy with the degree of Bachelor of Science



1 in Pharmacy (B.Sc.Phm.). This follows completion of a
2 four-year programme of studies after Grade XIII, which
3 includes:

- 4 1. Basic Sciences - Chemistry (Inorganic,
5 Organic, Analytical), Biochemistry, Physics,
6 Botany, Zoology, Microbiology, Physiology;
- 7 2. Humanities and social sciences - English,
8 Philosophy or Political Science or Anthro-
9 pology or another language, Economics, Psy-
10 chology;
- 11 3. Applied scientific and professional
12 courses in Pharmaceutics, Pharmaceutical
13 Chemistry, Pharmacognosy, Pharmacology and
14 Pharmacy Administration.

15 Provision is made in the fourth year for some elective
16 specialization in: hospital pharmacy, retail pharmacy,
17 industrial pharmacy, pharmaceutical chemistry and prepara-
18 tion for graduate study.

19 The teaching staff of the Faculty consists
20 of a dean, 4 professors, 5 assistant professors, 2 lectu-
21 rers in addition to about 18 part-time laboratory instruc-
22 tors. All of the 11 professors and lecturers possess high
23 academic qualifications, 9 hold a doctorate and the others
24 a master's degree. Most of them have well-developed
25 research programmes which have yielded a number of publica-
26 tions in scientific journals.

27 Since 1953 postgraduate study has been
28 offered leading to the degree of Master of Science in
29 Pharmacy. 20 students have successfully completed the
30 requisite courses and researches and have earned the



1 degree. 10 are at present enrolled in the programme. The
2 students have come from: India, Formosa, Thailand, British
3 Columbia, Saskatchewan and our own Province of Ontario.
4 The 20 who have completed the requirements are now engaged
5 as follows: 5 are in government laboratories, 7 hold
6 teaching positions, 2 are in industry, and 6 are continuing
7 their studies.

8 At present there are not being graduated
9 nearly enough candidates with higher degrees to meet the
10 requirements of industry, government laboratories, universi-
11 ties and hospitals. In order to meet these needs plans
12 are well advanced for a new building on the campus of the
13 University of Toronto which it is hoped will be ready in
14 1962. I might qualify that. I was notified by the Dean
15 yesterday it will be 1963. Provision is being made in it
16 for a considerable expansion of the facilities for graduate
17 study and research. It will be then possible to accommo-
18 date up to 35 graduate students. Excellent facilities are
19 also included for radioisotope research, microbiological
20 studies, instrumental analysis, small and large scale
21 formulation problems, drug plant extraction and analysis,
22 etc.

23 The new building will permit enrolment only
24 sufficient to graduate approximately 125 at the Bachelor's
25 level, i.e. total enrolment of slightly more than 500.
26 At present undergraduate enrolment totals around 380: 1st
27 year 103, 2nd year 116, 3rd year 98, 4th year 61.

28 As indicated above the Faculty of Pharmacy
29 of the University of Toronto is the only teaching body in
30 the field of pharmacy in the Province and the Ontario



1 College of Pharmacy is the licensing body.

2 The following figures show the number of
3 graduates of the Faculty of Pharmacy of the University of
4 Toronto who have been licensed by the Ontario College of
5 Pharmacy during the last five years:

6	1956	46
7	1957	45
8	1958	80
9	1959	69
10	1960	92

11 The Ontario College of Pharmacy also grants
12 the licence to those pharmacists from the other provinces
13 of Canada, and other countries of the world who, after
14 establishing residence in Ontario, meet the conditions for
15 the licence set down in the regulations to the Pharmacy
16 Act. These conditions include meeting academic and
17 apprenticeship requirements equivalent to the qualifica-
18 tions obtained by graduates of the Faculty of Pharmacy
19 and passing licensing examinations. During the past five
20 years the College has granted the licence to pharmacists
21 from other jurisdiction as follows:

22	1956	35
23	1957	37
24	1958	29
25	1959	29
26	1960	8

27 From these persons must come the replacements
28 for registered pharmacists to fill the normal requirements
29 for the hospital and retail pharmacies of the Province.
30 The figures for hospital and retail pharmacies for the



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1 last five years are as follows:

	<u>Retail Pharmacies</u>	<u>Hospital Pharmacies and Clinics</u>
1956	1936	
1957	1947	75
1958	1955	83
1959	1949	84
1960	1957	86

8 In 1936 no records had been started to be
9 kept concerning the hospital pharmacies and clinics.

10 The total number of registered pharmacists
11 in the Province for the last five years to staff the
12 above is as follows:

	1956	3642
14	1957	3730
15	1958	3728
16	1959	3790
17	1960	3828

18 The Ontario College of Pharmacy is governed
19 by a Council which is composed of 15 elected members and
20 the Dean of the Faculty of Pharmacy of the University of
21 Toronto. The elected members represent the 15 districts
22 into which the Province is divided, as set out in the
23 By-Laws. Elections to Council are held every two years.
24 Any registered pharmacist in Ontario in good standing may
25 stand for election if nominated by at least three other
26 members of the College in good standing in their respec-
27 tive districts.

28 There are four standing committees of
29 Council:

30



1 1. Education

2 2. Finance and Property

3 3. By-Laws and Legislation

4 4. Infringement

5 The Committee on Education is responsible
6 for the setting of standards for candidates for the
7 licence, for programmes of continuing education for the
8 practising pharmacist, for recruitment of students for
9 the Faculty of Pharmacy, and for a continuing study of
10 professional standards in equipment and library for the
11 practising pharmacist. This committee also deals with
12 applications for the licence from pharmacists from other
13 jurisdictions and holds personal interviews with such
14 candidates. Another duty is direction of the publication
15 of the Bulletin of the Ontario College of Pharmacy, a
16 professional scientific publication forwarded to all
17 members of the College and to educational institutions
18 throughout the world on their special request.

19 The Committee on Finance and Property
20 recommends the setting of fees payable by the members
21 under various categories for the use of the College, over-
22 sees the spending of the monies thus obtained, recommends
23 grants as specified under the Act, controls investments
24 and generally supervises the financial affairs of the
25 College. At present the committee has no property to
26 supervise as this was all transferred to the University of
27 Toronto in 1953.

28 The Committee on By-Laws and Legislation
29 is concerned with drafting of by-laws to facilitate the
30 working of Council, with legislation to properly safeguard



1 the public of the Province with respect to the distribution
2 of drugs and poisons, and with the proper supervision
3 and control of registrants.

4 The Committee on Infringement supervises
5 the work of the Inspection Department which is composed
6 of a Chief Inspector and three Inspectors in the field.
7 All four are registered pharmacists who regularly inspect
8 the pharmacies of the Province, continually endeavouring
9 to upgrade the practice of pharmacy and to keep pharmacists
10 aware of changes in the various Acts and regulations there-
11 of, both federal and provincial, which affect pharmacy.
12 The committee handles complaints about the conduct of
13 pharmacists and the operation of pharmacies and generally
14 speaking deals with minor infractions of the Pharmacy Act.

15 Under the Pharmacy Act, "The Council or the
16 discipline committee appointed under a by-law passed by
17 the Council may direct that the registration of any person
18 be cancelled, or that the registration of any person be
19 suspended, for such time as the Council or the discipline
20 committee deems proper, (a) if such person has been convic-
21 ted of an offence against any Act of the Parliament of
22 Canada or of the legislature of any province of Canada
23 relating to the sale of drugs, poisons, medicines or
24 alcoholic liquors; or (b) if such person has been
25 declared to be mentally incompetent under The Mental
26 Incompetency Act or has been certified or found to be
27 mentally ill under The Mental Hospitals Act; or (c) if it
28 finds that such person has been guilty of negligence,
29 incompetency or improper conduct in a professional
30 respect". (Section 29 (1)(a),(b),(c), The Pharmacy Act,



1 Revised Statutes of Ontario, 1960).

2 Special committees are constituted for each
3 Council term - the Council term is a two-year term - as
4 circumstances call for and have been as follows: Inter-
5 Relations, Public Relations, Health Insurance, Pharmacy
6 Act, Prescription Pricing, and Liaison with the College
7 of Physicians and Surgeons of Ontario.

8 The preceding information will, we trust,
9 give the Commission some understanding of the College
10 and its functions. We appreciate, however, that this
11 Commission might find it useful to have further details
12 regarding prescription pricing and the position the
13 College has taken in the matter.

14 To the best of our knowledge the first
15 mention of a guide or schedule of fees for prescriptions
16 in Canada was in February 1881 as a tariff for medicines
17 supplied to their patients by members of the College of
18 Physicians and Surgeons of the Province of Quebec. The
19 tariff included fees for mixtures and draughts, powders,
20 pills, lotions, liniments, blisters and plasters, and
21 ointments, with the note: "when costly drugs or medicines
22 are used, the charge to be augmented according to value".

23

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1 MR. MOISLEY: In the United States a fee
2 schedule was first established in Massachusetts as early
3 as 1828, the College of Pharmacy that is, the Massachusetts
4 College of Pharmacy, noting "that in their opinion a
5 judicious arrangement as to prices is no small means of
6 adding support and dignity to the business. They cannot
7 but hope, and think, that the prices as here set down will
8 be followed. This must be for the benefit of all. One
9 evil where there is a difference in prices is that the
10 purchaser either thinks that the one who charged high
11 wronged him as to price, or the one who charged low wronged
12 him as to quality".

13 Over the years many more schedules and
14 guides were introduced by various schools and colleges of
15 pharmacy, state associations and publications, the first
16 study being made at the national level by the American
17 Pharmaceutical Association in 1916. The following quota-
18 tion is from a paper presented at the Association's
19 Convention of that year, and I quote: "Let us consider
20 what price a prescription should bring. If the sum of
21 the cost of the ingredients, container, overhead expense,
22 and time for compounding is considered the cost to the
23 pharmacy of the finished prescription, then we must add
24 to this cost that of doing business; that is the general
25 merchandising overhead which takes care of the expense
26 of the front of the store, deliveries, losses through bad
27 accounts, cost of time of such clerks as wait on the
28 customer in taking in the prescription and handing him
29 the finished article, etc. Further, we must add the fee
30 to which we are entitled as professional persons for the



1 service rendered in filling a prescription and such additional
2 amount as to show the percentage of net profit that should
3 accrue from a transaction of this nature."

4 All the preceding would point up the fact
5 that guides and schedules are not of recent origin.
6 Therefore it is not strange that a committee of the Council
7 of the Ontario College of Pharmacy on December 6th, 1910,
8 studied a report of the Canadian Pharmaceutical Association
9 on "A scale of prices for ordinary prescriptions to be
10 obtained in Canada", adopted in open convention and recommended
11 to pharmacists throughout Canada. Satisfaction was
12 expressed with the report and Council recommended that
13 Divisional or District Associations be requested to give
14 prominence to the recommendation in their deliberations
15 and arrive at a scale of prices in harmony with this
16 suggestion and in accordance with local conditions.

17 On June 7, 1943, a brief on prescription
18 pricing was presented. Council members felt that the
19 brief clearly outlined the problem confronting our members
20 in operating their prescription departments. As a result
21 a motion was passed that instruction in the charging of
22 fees for the dispensing of prescriptions be added to the
23 school curriculum.

24 On June 10, 1943, the following motion was
25 passed: "Whereas it is apparent that the Druggists of the
26 Province of Ontario are looking for direction regarding the
27 value of their professional services when dispensing and
28 pricing prescriptions, and have applied to the Council for
29 leadership," it was regularly moved and seconded "that a
30 Committee of this Council be named to formulate a schedule



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1 of charges, and to work in conjunction with a similar
2 committee of the Ontario Retail Druggists' Association,
3 and to submit their findings at the next session of
4 Council". On November 18, 1943, the above committee
5 reported; a suggested schedule was approved and ordered
6 printed.

7 In November 1949 a special committee was
8 appointed to study and revise the existing suggested
9 prescription pricing schedule. Their report was approved
10 and later in the session the printing of 2000 copies of
11 the suggested method was authorized.

12 Mr. Chairman, at this time if you wish I
13 could file this copy with you. It is of June, 1950. I
14 don't believe you have it. The first one mentioned is
15 long ago, and I could not find any copies in the file at
16 all -- if you would care to have the first one that we
17 have a record of.

18 THE CHAIRMAN: That will become exhibit
19 T-21.

20
21 ---EXHIBIT NO. T-21: A suggested method of
22 prescription pricing.

23 In November 1953 the Education Committee
24 was authorized to review the current schedule and in June
25 1954 reported: "we have revised."The Method of Estimating
26 Dispensing Fees', as used in the College during the last
27 few years. We have made changes in the Schedule which
28 we felt were required because of changed conditions in
29 the practice of Pharmacy and submit same for your approval."
30 Council approved and authorized the printing of 2000 copies



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1 for distribution to the Dispensing Laboratory, Faculty
2 of Pharmacy, for the instruction of the students, and to
3 those pharmacists who requested them.

4 Several reprintings occurred from 1954 to
5 1957. In June 1957 a Health Insurance Study Committee
6 recommended a research study in prescription pricing.
7 This was authorized and in June 1958, after report of the
8 study was accepted, Council authorized the appointment
9 of a Special Committee on Prescription Pricing to study
10 methods of prescription pricing and report.

11 In November of 1958 Council approved "A
12 Suggested Method of Estimating Professional Dispensing
13 Fees". It was pointed out that, while this method would
14 be explained to the students in the Faculty of Pharmacy,
15 other plans would also be presented. Printing was
16 authorized and in November 1959 some minor changes were
17 authorized which gives us finally the method presently
18 recommended. I believe also, sir, that these were not
19 available when Mr. MacLeod made his visit, so I give you
20 now the latest method.

21 THE CHAIRMAN: This will become Exhibit
22 T-22.

23
24 ---EXHIBIT NO. T-22: A suggested method of
25 estimating professional
dispensing fees.

26
27 MR. FRAWLEY: What is the date of that?

28 THE CHAIRMAN: It says "Revised, January,
29 1960".

30 The guide was originally developed and used



1 as a teaching aid for students. It is being used by some
2 practising pharmacists as a simple guide in today's modern
3 practice. It must be pointed out that there are other
4 guides and methods in use throughout the province, such as
5 those used by pharmacists in Essex County, London, Hamilton,
6 Sudbury, Niagara Falls. Moreover, there are many pharmacists
7 who use their own methods of calculating prescription
8 prices and do not follow any guide.

9 It must surely be appreciated by this
10 Commission that the guide has been prepared with knowledge
11 not only of the provisions of The Combines Investigation
12 Act but also of the spirit and intent of that legislation.
13 It is submitted that the guide offends neither the statute
14 nor its intent, having regard to the peculiar nature of
15 the product involved, the professional skill exercised in
16 its distribution, the myriad number of drugs called for,
17 and the obvious desirability of having some rational
18 basis of arriving at a price for them. In the absence of
19 such a guide, the same prescription will be dispensed from
20 different pharmacies at prices that will vary by ridiculous
21 amounts. The College is not concerned with minor
22 differences in price from drug store to drug store but it
23 does find it difficult to reconcile, and indeed explain,
24 prices that vary as much as, or more than, 100 per cent.
25 The material before the Commission will illustrate the
26 complaints that are made to the College in this connection.
27 I refer to some of the correspondence which Mr. MacLeod
28 obtained from our office. At this point I would like to
29 bring to your attention, Mr. Chairman, an item in the
30 Telegram of Toronto, Monday, October 23, written by a staff



1 reporter, Fraser Kelly on a small survey that he did, and
2 I would like to file it with you as an exhibit.

3 I believe Mr. Turnbull made some reference
4 to it. I thought it should be filed as an exhibit on
5 conditions as they exist in Toronto.

6 THE CHAIRMAN: Yes. It was referred to by
7 Mr. Turnbull, but was not filed as an exhibit. This will
8 be exhibit T-23.

9

10 ---EXHIBIT NO. T-23: Article taken from the
11 Telegram, October 23, 1961.

12 MR.MOISLEY: The peculiar nature of the
13 distribution of drugs as compared to other goods suggests
14 that different considerations must apply. This was touched
15 upon in the statement of evidence in the Green Book:

16 See i page 43, paragraph 72, as to the impact of
17 the new wonder drugs.

18 ii page 57, paragraph 105(f), as to preparation
19 of dosage forms by manufacturers.

20 iii page 104, paragraph 182, as to the heavy
21 responsibility in dispensing drugs.

22 iv page 219, paragraphs 385 and 386, as to the
23 oversimplification of the generic and brand
24 name debate.

25 v page 239, paragraph 424, as to broad general
26 statements about the costs or selling prices
27 of drugs generally having little meaning.

28 vi page 256, paragraph 465, questioning if the
29 prescription fee should be determined solely
30 by the pharmacist and as to confusion between



1 remuneration received in retailing goods and
2 received in a professional capacity.

3 vii page 261, paragraph 482, as to cost being
4 only one consideration in the broad considera-
5 tion of the control of distribution of
6 drugs and narcotics in relation to public
7 health.

8 It is submitted that these references support
9 the conclusion that there are problems peculiar to pharmacy.
10 These problems are not all of recent origin and are by no
11 means simple of solution.

12 To repeat, the Ontario College of Pharmacy
13 is primarily a licensing body created by statute. Thus it
14 does not propose to comment on all of the matters dealt
15 with in the statement of evidence as many clearly outside
16 its jurisdiction. However, there are two which merit
17 reference.

18 First, the conclusion that "the practices
19 (of retail druggists) have resulted in the virtual elimina-
20 tion of price competition at the retail level", (See page
21 258, paragraph 468), and "there is virtually no price
22 competition in the sale of ethical drug products at the
23 retail price level", (See page 261, paragraph 482). The
24 statement of evidence does not disclose any details as to
25 how this conclusion was arrived at. Whatever was made
26 available to the Director, the College can only say that,
27 on the basis of its experience, there has been and there
28 continues to be a widespread variation in the prices at
29 which drugs are available to the public at the retail
30 level.



1 Second, the conclusions that "there is very
2 little price competition at the retail level" "due to the
3 pressure exerted by pharmacists' associations on their
4 members to maintain prices", (see page 260, paragraph
5 480). The prescription pricing guide of the Ontario
6 College of Pharmacy has been dealt with earlier in this
7 brief. However, the statement of evidence contains a
8 reference to legal proceedings involving Norman H. Englan-
9 der and his registration with the College, (see page 4,
10 paragraph 10, and page 91, paragraphs 156 and following).
11 Mr. Englander's testimony before the Commission is not
12 reproduced and thus no comment can be made. The suspi-
13 cions - and I underline suspicions - of a Toronto journa-
14 list were deemed relevant and are found in paragraph 156.
15 The College does not believe that this Commission intends
16 to deal with this matter on the basis of that kind of
17 evidence. However, the College does desire to make it
18 clear that the legal proceedings referred to arose out of
19 the nature and extent of Mr. Englander's proprietary
20 interest in the proposed pharmacy. In the result the
21 judgment of the Supreme Court of Ontario dealt only with
22 the Registrar's discretion in accepting or rejecting regi-
23 stration.

24 MR. FRAWLEY: What happened in the Supreme
25 Court Mr. Moisley, because I have no familiarity with
26 these proceedings at all?

27 MR. ISBISTER: Perhaps I can help my friend.
28 As the concluding sentence in the paragraph indicates,
29 the proceedings were by way of an application for an
30 order of mandamus. The order was made. The court held



1 that under that particular section of the Act, the section
2 that dealt with the registration of pharmacies, the court
3 held that provided that the notice which is given to the
4 College complied with the section, the Registrar has no
5 discretion.

6 He accepts the notice and the notice becomes
7 a matter of record at the College and that is the end of
8 it. The question of the nature or extent of Mr. Englan-
9 der's proprietary interest was not gone into in those
10 proceedings because it was not necessary, and as I say,
11 the case was solely a question of the construction of the
12 section of the Act to determine whether or not the Regis-
13 trar could exercise a discretion in accepting or rejecting
14 - not what is ordinarily a registration. I might tell
15 the Commission sir that the Act provides for notice being
16 given by anyone who wishes to open a pharmacy or move
17 from one address to the other. The question was whether
18 or not this notice was to be taken and made part of the
19 records.

20 I don't want to embark on what became a
21 matter before the Court of Appeal in another case, but
22 the significance of it sir is this: if that notice does
23 not become part of the records, the drug houses will not
24 furnish a store with drugs or narcotics.

25 THE CHAIRMAN: Isn't it part of the law of
26 this Province that the pharmacy must be operated by the
27 owner or owned--the majority of the shares must be held
28 by a pharmacist?

29 MR. ISBISTER: That is right.

30 THE CHAIRMAN: Wouldn't that be necessary in



1 a future application?

2 MR. ISBISTER: Yes sir, but the court held
3 provided that particulars are given, the Registrar does
4 not have the discretion to go behind the particulars.

5 THE CHAIRMAN: You mean if the applicant
6 claims to be the owner?

7 MR. ISBISTER: That is right sir.

8 THE CHAIRMAN: The Registrar has not the
9 right to prove that he is not, is that what that means?

10 MR. ISBISTER: Well I wouldn't go quite
11 that far sir. It certainly went this far within the
12 circumstances of that case: The Registrar could not
13 refer it to counsel. The court held he was an administra-
14 tive officer and could not exercise a judicial office
15 or weigh it this way or that way. He was an administra-
16 tive arm.

17 If the notice complied with the Act in the
18 sense that the various points were dealt with, he must
19 accept the particulars and make it a matter of record.

20 What the result would be sir if the infor-
21 mation was incorrect might be a different matter. I
22 believe there was a subsequent case where that question
23 did arise but in this particular case the simple question
24 before the court was, as I have said already too often,
25 the question of an administrative officer and his function.

26 THE CHAIRMAN: Administrative rather than
27 executive?

28 MR. FRAWLEY: Mr. Englander asked for a
29 mandamus and the College was required to register it?

30 MR. ISBISTER: That is right, and that



1 settled the question. Excuse me sir, if I might just
2 refer the section of the Act, Section 25 is the section
3 that was considered together with Section 19.

4 THE CHAIRMAN: Of the Ontario Pharmacy Act?

5 MR. ISBISTER: Yes Mr. Chairman, Chapter 295
6 of the Revised Statutes of Ontario, 1960.

7 MR. MACLEOD: Perhaps I might point out sir
8 that on the examination of Mr. Englander a photostatic
9 copy of the pleadings of the case referred to were taken
10 and they will be among the documents put before the
11 Commission.

12 THE CHAIRMAN: I might say, just in reference
13 to the statement in the brief, a slight slip, which fre-
14 quently occurs, was made. Mr. Englander's testimony was
15 not given before the Commission, as I recall it. It was
16 given - isn't that correct? Did Mr. Englander appear
17 before the Commission himself?

18 MR. MACLEOD: He appeared before Mr. Whiteley.

19 THE CHAIRMAN: It was not a part of these
20 proceedings before the Commission. It was what they call
21 the Director's inquiry stage of the proceedings.

22 MR. MOISLEY: We are not advised of that
23 Mr. Chairman. In our opinion a private meeting was held
24 and Mr. Englander was under oath.

25 THE CHAIRMAN: Oh yes, but it is a different
26 stage of the proceedings. That is all. It is not before
27 the whole Commission.

28 MR. FRAWLEY: Do I understand it that if
29 anything turned on it those proceedings would be available
30 as part of this Commission?



1 THE CHAIRMAN: Yes. Anything that is taken
2 before the Director is available to the Commission. What
3 I am saying is it was not actually at a sitting of the
4 Commission.

5 MR. FRAWLEY: The statement says Mr. Englan-
6 der's testimony before the Commission and this is not
7 reproduced. My only point is if someone thought it was
8 important, it would be available?

9 THE CHAIRMAN: It could be made available.
10 It is not reproduced in the Director's volume of material.

11 MR. FRAWLEY: The thing is, if the College
12 or anyone else thought it was of some importance it
13 would be available on request? Or is there any question
14 about that?

15 THE CHAIRMAN: It is available to the
16 Commission. There is some question whether it is available
17 to everybody else. There are some legal proceedings
18 arising out of a different kind of inquiry in other pro-
19 vinces which have not yet terminated.

20 MR. FRAWLEY: This having been available
21 to everybody - I just want to understand it.

22 THE CHAIRMAN: The Commission has taken the
23 position that matters which may involve the party to the
24 proceedings, they are entitled to. That is, what the
25 Director relies on in the face of any allegation. The
26 person about whom any allegation is made has a right to
27 see those, and should be entitled to see those facts,
28 that material. We have taken that position but there are
29 some legal proceedings arising out of the case in British
30 Columbia where they have not yet been terminated in which



1 that position has been attacked. The question is whether
2 the Courts will agree with the view of the Commission,
3 or the other side. Until the Supreme Court has decided -
4 I think it is the Supreme Court - we won't know for sure
5 just where we stand. In this instance there are no alle-
6 gations. It is not that kind of inquiry. It is a differ-
7 ent kind of inquiry and it is really a matter of the
8 Commission getting information out of the preliminary
9 steps taken by the Director over a considerable period of
10 time and at the hearings which we have been conducting.

11 MR. FRAWLEY: The only reason I raised the
12 question was I do appreciate there are these perhaps
13 different sort of proceedings. In other instances this
14 statement of material has not been made available to the
15 public.

16 THE CHAIRMAN: No.

17 MR. FRAWLEY: And distributed very widely,
18 as this has been done, and that is the only reason - I
19 regard this as a very wide open inquiry. Otherwise, of
20 course, I would not be here. That is the only reason I
21 raised that. I wouldn't like to think there was anything
22 about the inquiry into drugs that would not be made
23 available upon proper demand.

24 THE CHAIRMAN: I think that is the position
25 that the Commission would take.

26 MR. MOISLEY: In conclusion, reference is
27 made to the question raised as to "the duality of interest
28 of the members of the governing body", (see page 11, para-
29 graph 24). To quote further from the same paragraph,
30 "Thus the question of professional ethics, which is a



1 field in which the governing body is normally given cer-
2 tain jurisdiction under the relevant legislation, appears
3 at times to be confused with the question of purely econo-
4 mic and business practices such as aggressive advertising
5 or even simple price competition". It is submitted that
6 there is no clear line to be drawn and that business and
7 economic practices cannot be completely divorced from the
8 ethics of the profession. The College believes that it
9 has a duty to the profession and to the public to give
10 its apprentices and registrants some guide as to the
11 compensation to which they are entitled for the profes-
12 sional service rendered. This is well accepted practice
13 in other fields of professional endeavour. The fact that
14 such compensation is an ingredient of a final price for
15 goods supplied has, however, tended to confuse the ques-
16 tion. The College has not, and it is submitted that
17 there is no evidence to the contrary, demanded that there
18 be adherence to the guide.

19 Finally, if, as a result of this inquiry,
20 there is a wider understanding of this aspect of pharmacy
21 and a greater appreciation of the peculiar but important
22 role which the pharmacist plays in protecting the health
23 of the nation, then, Mr. Chairman, this profession will
24 be in your debt.

25 THE CHAIRMAN: Do you wish to add any
26 comments to what is contained in the brief?

27 MR. MOISLEY: I don't believe so Mr. Chair-
28 man.

29 THE CHAIRMAN: There are one or two questions
30 that occurred to me. One is purely a matter of getting



1 the education position completely clear. You referred to
2 the fact that a Masters degree is now granted and that a
3 number of students are proceeding to a Masters degree and
4 then you mentioned also that on the staff there are, I
5 think it is, 9 doctors? Does the University of Toronto
6 grant any doctors' degree now in pharmacy?

7 MR. MOISLEY: Not at present, but it is
8 hoped that with the new facilities that that will be one
9 of the accomplishments.

10 THE CHAIRMAN: The doctors have obtained
11 them from other universities?

12 MR. MOISLEY: Elsewhere. I might say in
13 the development of the staff, it was at that time done by
14 the College. These men were sent away at College expense
15 to other universities throughout the United States and
16 Canada, and obtained this doctors' degree and they were
17 brought back to the College and added to the staff.

18 THE CHAIRMAN: They got them from other
19 universities in the United States or Canada?

20 MR. MOISLEY: That is right.

21 THE CHAIRMAN: One further question arises
22 in connection with this professional fee. Does the
23 College regard the whole of the service rendered by a
24 pharmacist in connection with his prescription work as a
25 professional service or does it regard it partly as a
26 professional service for which a profession is required,
27 together with the sale of goods?

28 MR. MOISLEY: That is a question sir.

29 THE CHAIRMAN: What position do you take in
30 that regard?



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1 MR. MOISLEY: I believe that we should say
2 this is the professional aspect of pharmacy and as such
3 that is, as you gather from the brief, the only aspect,
4 more or less, that the College is interested in is the
5 professional aspect, that is, the operation in a dispens-
6 sing laboratory.

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1 MR. MOISLEY: The sale of other goods, the
2 College isn't concerned about, providing, of course, that
3 certain standards are met, that is standards of practice.

4 THE CHAIRMAN: There are other drugs besides
5 prescription drugs.

6 MR. MOISLEY: That is correct, that these
7 are sold under proper conditions. We do give a certain
8 amount of supervision of the stores and see they are pro-
9 perly conducted and all that sort of thing. Our main
10 interest is in the dispensing of drugs.

11 THE CHAIRMAN: I raised the question partly
12 because of the language in the guide, Exhibit T-22, which
13 contains a reference to the fee and then to selling price,
14 which rather suggests the combination of services, that
15 is both professional work as a pharmacist and merchandise
16 or selling function.

17 MR. MOISLEY: You can't very well get away
18 from it because you start with an article of commerce
19 which is probably purchased from somewhere. That is the
20 starting point.

21 THE CHAIRMAN: You have an article of
22 commerce which is handled in a professional manner?

23 MR. MOISLEY: That is correct.

24 THE CHAIRMAN: Do you wish to raise any
25 questions, Mr. Isbister?

26 MR. ISBISTER: No, I have nothing else to
27 add unless there is something I can help with. I hope
28 you won't ask me to help you on the pricing list, the
29 exhibit, I don't understand it myself. Mr. Moisley and
30 some of the other gentlemen can.



1 THE CHAIRMAN: We will probably want to
2 study it a while before we will be in a position to ask
3 any questions. Mr. MacLeod, do you have any questions
4 or do you wish to follow Mr. Frawley? I think it would
5 be better if Mr. MacLeod wound up the questioning because
6 as I have said before it makes it unnecessary for him to
7 rise three or four times to question.

8 MR. FRAWLEY: Mr. Moisley, I want to be
9 clear about the relationship between the Association,
10 the Ontario Retail Pharmacists' Association - there is
11 such an Association, is there not?

12 MR. MOISLEY: Yes sir.

13 MR. FRAWLEY: Is it in association with the
14 College of Pharmacy?

15 MR. MOISLEY: No sir, except that its members
16 are registrants.

17 MR. FRAWLEY: Is the College of Pharmacy,
18 the Faculty of the College of Pharmacy of the University
19 of Alberta - are those two things identical?

20 THE CHAIRMAN: You said Alberta?

21 MR. FRAWLEY: Did I say Alberta? There is
22 a Faculty of the University of Toronto. In this historical
23 review you explained there is now in the University of
24 Toronto a Faculty of Pharmacy?

25 MR. MOISLEY: That is correct.

26 MR. FRAWLEY: A Faculty of Pharmacy and
27 there is a Dean and staff of that Faculty?

28 MR. MOISLEY: Yes sir.

29 MR. FRAWLEY: Is it wholly separate from the
30 College of Pharmacy which is an incorporated body and



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1 which you represent this morning?

2 MR. MOISLEY: Yes sir.

3 MR. FRAWLEY: It is quite separate?

4 MR. MOISLEY: Yes sir.

5 MR. FRAWLEY: And the Faculty of Pharmacy
6 nor any of its members are taking part in this presenta-
7 tion?

8 MR. MOISLEY: No sir.

9 MR. ISBISTER: Except the Dean is a member
10 of Council.

11 MR. MOISLEY: The academic qualifications
12 were naturally outlined by the Dean and they are incor-
13 porated in the brief.

14 MR. FRAWLEY: Primarily the College of
15 Pharmacy is a body from which a licence must be obtained
16 after a student has graduated from the University of
17 Toronto Faculty of Pharmacy?

18 MR. MOISLEY: And after he serves a further
19 twelve months period of internship, that is correct.

20 MR. FRAWLEY: He graduates from the Univer-
21 sity and he articles with a pharmacist and then the
22 College of Pharmacy will licence him?

23 MR. MOISLEY: That is correct.

24 MR. FRAWLEY: Regardless of how many degrees
25 or how proficient he was in his studies he must have a
26 licence from the College of Pharmacy before he can prac-
27 tise pharmacy or operate a drugstore as a pharmacist in
28 Ontario?

29 MR. MOISLEY: That is correct, sir.

30 MR. FRAWLEY: Now, the University Faculty,



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1 of course, is not concerned with pricing policy?

2 MR. MOISLEY: No.

3 MR. FRAWLEY: No. There is close associa-
4 tion between the University Faculty and the College of
5 Pharmacy but they are separate things?

6 MR. MOISLEY: That is correct, sir. I
7 mentioned in the brief that the Dean of Faculty sits as
8 a member of Council.

9 MR. FRAWLEY: If I may say, the use of the
10 word "College" is a little confusing because your College
11 used to be on Gerrard Street.

12 MR. MCISLEY: It still is.

13 MR. FRAWLEY: There was no association in
14 those days with the University of Toronto?

15 MR. MOISLEY: Except the granting of degrees
16 for examinations.

17 MR. FRAWLEY: Well now, there are some other
18 things I want to ask you about. You say at the bottom of
19 page 10 in the absence of such a guide the same prescrip-
20 tion will be dispensed from different pharmacies at prices
21 that will vary by ridiculous amounts. Do you mean that
22 the condition is obtained when the guide is disregarded or
23 do you simply think if there was no guide the same pres-
24 criptions would be dispensed from different pharmacies
25 at prices that will vary by ridiculous amounts?

26 MR. MOISLEY: Mr. Frawley, I think it is
27 very evident that this condition still exists as proven
28 by a survey which I have filed as an exhibit.

29 MR. FRAWLEY: Then we are on common ground
30 and I want to ask you some questions. You are saying that



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1 prescriptions are dispensed from different pharmacies at
2 prices that will vary by ridiculous amounts?

3 MR. MOISLEY: Do vary by ridiculous amounts.

4 MR. FRAWLEY: Can you tell me whether or not
5 that you find a prescription for 16 of Bristol's Poly-
6 cycline will vary from pharmacy to pharmacy by ridiculous
7 amounts?

8 MR. MOISLEY: I can't answer that. There is
9 no indication of that. The only thing I can say is
10 practically 90% of the complaints that come across my
11 desk from the public are concerned with the variation in
12 price of the same prescription from store to store.

13 MR. FRAWLEY: As you analyse these complaints,
14 Mr. Moisley, have you found to what extent the broad
15 spectrum antibiotics, the ataractics and corticosteroids
16 are in the complaints?

17 MR. MOISLEY: Mr. Frawley, I haven't the
18 time and I haven't the staff to institute such an investi-
19 gation.

20 MR. FRAWLEY: I suggest to you and please
21 correct me if my presumption is wrong, I suggest to you
22 you would find very few complaints that there divergencies
23 in the prices in Ontario pharmacies for the broad spectrum
24 antibiotics, the ataractics and the corticosteroids on
25 prescriptions? Is that a fair statement?

26 MR. MOISLEY: I wouldn't say so at the pre-
27 sent time. I am not informed as to these things. I
28 would like to ask you where you got your information.

29 THE CHAIRMAN: You are answering the
30 questions.



1 MR. FRAWLEY: One witness at a time is
2 enough. I simply suggest to you, you spoke of complaints
3 and you are the person, and I say so with deference, you
4 are the person who receives these complaints.

5 MR. MOISLEY: That is true.

6 MR. FRAWLEY: I ask you if you can recall
7 for the Commission that there was no great proportion of
8 complaints for prescription prices for ataractics, corti-
9 costeroids and broad spectrum antibiotics, that is all?

10 MR. MOISLEY: I can answer that Mr. Frawley,
11 in this way: many of the complaints that come in by 'phone
12 - many of them never materialize. They are not carried
13 through. When I ask the people 'phoning to bring in their
14 prescription and let me have a look at it they never come
15 through with it. Possibly the best way to answer your
16 question would be to say this, a week ago today a gentle-
17 man 'phoned and said he was in the habit of having a
18 prescription filled at his community pharmacy for a number
19 of years - not a number of years, a period of time. He
20 was paying in the neighbourhood of \$3.60, I believe it was,
21 which would possibly indicate to me that it might be one
22 of these drugs with which you are concerned. He said for
23 reasons of my own I had the prescription filled at a phar-
24 macy near the place where I work and the charge was \$6.60.
25 How do you explain it? Naturally, my reply to him is I
26 can't explain it until I see the prescription and the
27 product and find out something about it. The gentleman
28 who complained has never come in and that was a week ago.

29 MR. FRAWLEY: He didn't bring in the pres-
30 cription?



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1 MR. MOISLEY: No.

2 MR. FRAWLEY: Did he tell you what the
3 prescription was?

4 MR. MOISLEY: No.

5 THE CHAIRMAN: Mr. Moisley, would he be
6 complaining because of the variation of the prices or
7 because the recent price was higher?

8 MR. MOISLEY: Variation, sir, he wanted to
9 know why.

10 THE CHAIRMAN: Would he have complained for
11 the same reason if the price had been lower?

12 MR. MOISLEY: I doubt it. If it had been
13 lower we would never have heard.

14 MR. ISBISTER: He would have complained
15 about the first one.

16 MR. FRAWLEY: The newspaper clipping you
17 have brought to the attention of the Commission - is
18 that the only survey, if you want to dignify it by that
19 word, that has come to your attention?

20 MR. MOISLEY: No sir - well, recently, sir.
21 Approximately two years ago there was a survey made by
22 the same paper. I understand twelve prescriptions were
23 taken to twelve downtown stores and there was a variation
24 of 27% in the pricing of these prescriptions.

25 MR. FRAWLEY: For the record, and I think
26 it is well to put it on the record what the newspaper
27 reporter was investigating was Dical-D capsules. That
28 is Abbott's dicalcium phosphate and Viosterol, vitamin D
29 tablets of 100 or a thousand. You, of course, as I say,
30 are aware that the list prices, such prices in the price



1 book that Mr. Turnbull's Association filed yesterday for
2 all of the broad spectrum antibiotics are the same.

3 MR. MOISLEY: The same?

4 MR. FRAWLEY: I will go through them if you
5 want. At some pains to me I have written them out.

6 THE CHAIRMAN: Your question is not completely
7 clear. You don't mean the prices of all broad spectrum
8 antibiotics are the same, but the same broad spectrum
9 antibiotics will be the same price when made by a number
10 of manufacturers?

11 MR. FRAWLEY: Four or five tetracyclines
12 will be the same price. For instance, Lederle's Achromycin;
13 Bristol's Polycycline; Pfizer's Tetracyn and Squibb's
14 Steclin were all the same price. Now, talking about the
15 things I am interested in, I don't want to talk about
16 Viosterol. Talking about things I am interested in, I
17 have put it to you there is no ridiculous difference in
18 the prescription price of those drugs.

19 MR. ISBISTER: I don't want to cut my
20 friend's examination off, I point out to him the list
21 prices to which he has referred are the list prices of
22 manufacturers and that our people, our College has no
23 jurisdiction and certainly Mr. Moisley in his capacity
24 as Treasurer has no jurisdiction. He has been in the
25 field of pharmacy for years and if he can help on this
26 matter I am sure he will be glad to do so. Certainly in
27 his capacity as Registrar-Treasurer of the College of
28 Pharmacy, this is something with which he cannot concern
29 himself.



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1 MR. FRAWLEY: Of course my friend, Mr.
2 Isbister, perhaps does not understand me. I am talking
3 about the price book that is in the drug store. You told
4 us this morning that you had two practising chemists here,
5 Mr. Caldwell and Mr. Isaacson, and I am talking about the
6 book that can in all probability be found in their dis-
7 pensary, and the book which contains the list price which
8 is published by the Province of Ontario.

9 It is the prices of the broad spectrum
10 antibiotics, and the tetracyclines that I mentioned, and
11 whether or not they are made by the manufacturer, -- I
12 agree with you they are suggested by the manufacturer, --
13 but they are followed and used when you and I go into the
14 dispensary and purchase drugs.

15 THE CHAIRMAN: The question you are asking
16 is, to what extent they are followed?

17 MR. FRAWLEY: That is exactly what I am
18 asking. If I find in this book -- and I find that today's
19 list price for -- and I might as well make myself very
20 clear to you here, what I am talking about -- if I find
21 that today's list price for those drugs, in the 21st edition
22 of the price book published by the Canadian Pharmaceutical
23 Association, 221 Victoria Street, Toronto, for Deranil is
24 \$9.40 for 30, for Upjohn's Medrol is \$6.05 for 30, if I
25 find that the price for Schering's Meticorten is \$7.10 for
26 30, I simply put it to you that in your experience on the
27 receiving end of the complaints, do you find that there is
28 a ridiculous disparity on the prices which the prescription
29 purchasers in Toronto are asked for, the prices of those
30 antibiotics, that is all, Mr. Moisley?



1 MR. MOISLEY: Well, Mr. Frawley, as I have
2 indicated to you I cannot answer your question because I
3 have no figures pertaining to those products.

4 MR. FRAWLEY: Perhaps you are not the
5 person I should ask, so we will have to let that go. I
6 thought you were the custodian of the complaints and that
7 you would have this price book as part of your equipment.

8 MR. MOISLEY: No sir.

9 MR. FRAWLEY: In your office, you don't
10 have this price book?

11 MR. MOISLEY: No.

12 MR. FRAWLEY: It is a very handy thing to
13 have. I think I will buy one for myself.

14 Now, Mr. Moisley, from the evidence before
15 the Commission, there does not appear to be any very great
16 amount of manufacturing of basic drugs in Canada, is that
17 your understanding too?

18 MR. MOISLEY: Yes, in a sense.

19 MR. FRAWLEY: Why is that?

20 MR. MOISLEY: Well, here again, Mr. Frawley,
21 we are getting out of my field. I am an administrative
22 officer for a provincial licensing body and I have
23 peculiar problems of my own, and I am not interested in
24 the manufacturing industry.

25 MR. FRAWLEY: I will ask you something else
26 and perhaps you cannot answer it. Probably some of these
27 gentlemen can. I take it, Mr. Isbister, that is why you
28 have Mr. Caldwell and Mr. Isaacson here in case Mr. Moisley
29 would not be able to answer these questions, or if you
30 feel differently, just say so.



1 MR. ISBISTER: I don't think you should
2 take too much of anything at this stage.

3 MR. FRAWLEY: All right, I will ask the
4 question at this point. Is there any bargaining between
5 the retail pharmacist and the manufacturer, in connection
6 with the price he must pay for the drugs which he buys
7 and prescribes, and I am naturally speaking of broad
8 spectrum antibiotics, ataractics and corticosteroids.

9 MR. MOISLEY: If there was, Mr. Frawley,
10 I would not be aware of it.

11 MR. FRAWLEY: You are not aware that there
12 is any bargaining, whether there is or is not any bar-
13 gaining between the retail pharmacist and the manufacturer,
14 if he buys from the manufacturer, or the wholesaler if
15 he buys from the wholesaler, with respect to the price at
16 which he buys which has a discount under the list price.
17 You are not aware of any bargaining that does or does not
18 go on?

19 MR. MOISLEY: Let us put it very simply,
20 it is none of my business.

21 MR. FRAWLEY: I certainly have no problems
22 to demand that involve Mr. Caldwell or Mr. Isaacson be
23 asked, I am in the hands of the Commission. We talked
24 about it yesterday and at the time we had in the witness
25 stand the manager of the Canadian Pharmaceutical Associa-
26 tion. He had been in active practice for ten years before
27 and you might recall there was some absence of current
28 knowledge. So I felt it was fortunate, Mr. Isbister that
29 I have two practising pharmacists with Mr. Moisley.

30 THE CHAIRMAN: I think we will let that



1 stand until Mr. Moisley's evidence has been completed and
2 then let us ascertain whether either of the other gentle-
3 men might be able to answer those questions.

4 MR. FRAWLEY: All right. Now, Mr. Moisley,
5 speaking about the duality of interests, I am not certain
6 whether or not you took exception to what is set down in
7 the Green Book in that regard or whether you acknowledge
8 the duality and accept its propriety and its inevitability.
9 What is your position with regard to the suggestion that
10 there is duality of interests?

11 MR. MOISLEY: Now, Mr. Frawley, all I can
12 say is we take no objection to anything that is in the
13 Green Book except as we have stated in our brief. We set
14 it out.

15 MR. FRAWLEY: Let me see what you say.
16 After the quotation: "It is submitted that there is no
17 clear line to be drawn that the business and economic
18 practices cannot be completely divorced from the ethics
19 of the profession".

20 MR. MOISLEY: What page is that, sir,
21 please?

22 MR. ISBISTER: The bottom of page 12.

23 MR. MOISLEY: What is the question again
24 please, Mr. Frawley?

25 MR. FRAWLEY: I was simply asking whether
26 or not you take any exception to the statement in the
27 report that there is a duality of interests?

28 MR. MOISLEY: No, we don't take any
29 exception.

30 MR. FRAWLEY: All right thank you. That is



1 all.

2 THE CHAIRMAN: Mr. MacLeod?

3 MR. MacLEOD: Mr. Moisley, you have filed
4 a number of copies of the Guide. I have an additional
5 copy here which is marked "Developed by Professor H. J.
6 Fuller" and there is a note that it was reprinted on
7 February 15, 1958. Is that part of the series of guides
8 issued by the College?

9 MR. MOISLEY: Yes, reprinted February 15,
10 1958.

11 MR. MacLEOD: That would have been reprinted
12 by the College?

13 MR. MOISLEY: Yes.

14 MR. MacLEOD: So the fact that it bears
15 the notation "Developed by Professor Fuller", does not
16 mean that is a separate guide?

17 MR. MOISLEY: No.

18 MR. MacLEOD: Will you look at T-22 and
19 can you tell me by looking at T-22 what is the suggested
20 price for 50 tablets when the list price for 100 tablets
21 is \$10.50 and you are a pharmacist required to supply the
22 patient with 50 of the prescription.

23 MR. MOISLEY: Well, Mr. MacLeod, with your
24 permission and with the permission of the Chairman, I
25 think this is a proper question for the chairman of the
26 Committee who developed the guide. After all, as I
27 mentioned to you, I am merely an administrative officer
28 and carry out the directions of Council to the best of
29 my ability.

30 MR. MacLEOD: And that would be Mr. Isaacson



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1 who is here?

2 MR. MOISLEY: He is here for that purpose.

3 MR. MacLEOD: Then, we will ask Mr. Isaacson.

4 Will you again direct your attention to T-22 and on the
5 very first page this appears, "This suggested method is
6 published by the Ontario College of Pharmacy as a guide to
7 the fair and equitable pricing of prescription purposes.
8 Its use is recommended to all practising pharmacists in
9 the Province of Ontario". Is that the recommendation of
10 the College, "Its use is recommended"? Does that mean the
11 College is recommending it?

12 MR. MOISLEY: That is correct.

13 MR. MacLEOD: Does the College to your
14 knowledge take any stand on the coding of prescriptions,
15 that is putting code letters on to indicate the price
16 which the druggist has charged for that particular pres-
17 cripition?

18 MR. MOISLEY: No sir.

19 MR. MacLEOD: To the best of your knowledge
20 the College has no official stand in that matter?

21 MR. MOISLEY: No sir.

22 MR. MacLEOD: Jumping around a little bit,
23 there has been some suggestion of a shortage of pharmacists,
24 and I think your brief indicates that you share that view,
25 that there is a shortage of pharmacists?

26 MR. MOISLEY: Yes sir.

27 MR. MacLEOD: Is it a fact that graduating
28 pharmacists are being drawn more and more into industry
29 and being employed as detailmen and that sort of thing,
30 and government, rather than setting up their own stores?



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1 MR. MOISLEY: I would say that there is
2 a trend. Our understanding is that government can use
3 many more pharmacists than they now have, and they don't
4 seem to be getting enough to fill their demands in the
5 various departments in which there is a place for them.

6 MR. MacLEOD: I was wondering if in your
7 opinion the effect of these conditions is likely to be
8 felt at the retail level, in that in the future we may
9 have a smaller number of stores or something of that kind?

10 MR. MOISLEY: I believe, Mr. MacLeod, that
11 is a question of economics. There is a trend possibly
12 today for pharmacists who have had smaller operations to
13 close them and to go into partnership with another
14 pharmacist, another operation which is larger and better
15 suited to serve the community, than possibly to these
16 smaller stores. That is happening in the Metro area right
17 now, and of course by economics again, many of those
18 pharmacists, self employed, can now earn a better income
19 working for someone else than they could possibly enjoy
20 in their own operation.

21 MR. MacLEOD: The point I was addressing
22 myself to was whether or not the shortage of pharmacists,
23 if it exists, is likely in the foreseeable future to
24 change the conditions at the retail level.

25 MR. MOISLEY: It could possibly, yes.

26 THE CHAIRMAN: Just to be clear on that
27 point, do you see any specific trend? I am thinking for
28 instance is there a trend towards an increase in the
29 number of pharmacists which operate purely professional
30 types of business rather than combined professional and



1 front store operation?

2 MR. MOISLEY: That type of business is
3 increasing in Ontario presently. There are more pro-
4 fessional operations being started. I might add, speaking
5 of the scarcity of pharmacists, that many hospitals cannot
6 find pharmacists to take charge of their operation, and
7 of course with the spread in demand under the Ontario
8 Hospital Services Commission for pharmaceutical services,
9 that is proper pharmaceutical services in hospitals,
10 this is one of our problems, to have people available for
11 these positions.

12 THE CHAIRMAN: I was thinking a pharmacist
13 who is doing a purely professional operation is able to
14 serve, I would think, a greater number of people than one
15 who is doing a front store operation, as they frequently
16 do in a very small store.

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1 MR. MOISLEY: I would qualify that, Mr.
2 Chairman. That would depend on the community which it
3 serves and many other things which enter into it.

4 I mentioned the demand for people for hospi-
5 tals and in our brief we mentioned the continuing educa-
6 tion of the practising pharmacists. That is something
7 we are studying just at present, to make something
8 available whereby the community pharmacist - I am speaking
9 of the smaller areas, smaller towns where they have small
10 hospitals and they could not possibly hire a full-time
11 pharmacist - we are hoping within a year to have something
12 in the way of continuing education available to those phar-
13 macists in those areas, where, by taking a refresher course
14 or something of this nature, they may be able to serve
15 these hospitals on a part-time basis.

16 THE CHAIRMAN: The question I asked had to
17 do with this sort of view, if a man was putting in full
18 time on prescriptions, he should be able to perform those
19 services for more people than one who was putting in a
20 third of his time or half of his time serving over the
21 counter.

22 MR. MOISLEY: That is true, but it depends
23 on the community in which his business is located, the
24 availability to a large number of people.

25 THE CHAIRMAN: If he would get enough busi-
26 ness to occupy his time.

27 MR. MOISLEY: Again, he must have a good
28 front shop operation to support his prescription depart-
29 ment.

30 THE CHAIRMAN: Another point there, from



1 1956 to 1960, the number of graduates has actually doubled
2 with a certain number coming in from other parts of the
3 country. Does your brief mean that in spite of this
4 increase, more are being needed than are being provided?
5 The increase is not sufficient to take care of the
6 increase in needs?

7 MR. MOISLEY: And particularly in hospital
8 pharmacy. That is where the great demand is at present.

9 THE CHAIRMAN: You will be a little while,
10 will you, Mr. MacLeod?

11 MR. MACLEOD: Not with Mr. Moisley. There
12 are, however, a few questions I want to ask Mr. Isaacson.

13 THE CHAIRMAN: We are after half-past
14 eleven, and perhaps we might have a short break.

15
16 --- Short Recess

17
18 MR. MACLEOD: Mr. Moisley, would the College
19 regard advertising of prescriptions and cut-rates as
20 being unethical?

21 MR. MOISLEY: I would say yes, Mr. MacLeod.
22 It would naturally, of course, depend on the reading of
23 the ad and what the ad is composed of. That would be
24 taken care of in our Code of Professional Conduct. I
25 can file this with the Commission.

26 THE CHAIRMAN: That will be Exhibit T-24.

27
28 --- EXHIBIT NO. T-24: Code of Professional Conduct

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1 MR. MOISLEY: But other than that, it would
2 depend a lot on the statements which were made, and that
3 would have a bearing on it. That is all I can say, sir.

4 MR. MACLEOD: Is there a general feeling
5 in your College that price cutting is undesirable in this
6 field, in the pharmaceutical field?

7 MR. MOISLEY: Prescription services, yes.

8 MR. MACLEOD: And as regards other drugs?

9 MR. MOISLEY: We are not concerned, sir.

10 MR. MACLEOD: Now, referring just for a
11 moment to the Englander matter, while I realize the legal
12 position and the grounds on which the case went to court,
13 was not the feeling of the Association that it was undesir-
14 able that a pharmacy should operate in a discount house?

15 MR. MOISLEY: No. I would say no, an
16 unqualified no to your suggestion, Mr. MacLeod. It was
17 the environment with which we were concerned.

18 MR. MACLEOD: Well, perhaps you will make
19 that distinction and elaborate on that a bit.

20 MR. MOISLEY: Well, personally, I have
21 never been in Honest Ed's. I can't answer from that
22 point, but personally I did not feel it was a proper
23 type of place to have a pharmacy, a professional pharmacy
24 located in.

25 MR. MACLEOD: Why?

26 MR. MOISLEY: Well, just the makeup of the
27 place, that is all.

28 MR. MACLEOD: The pricing policies followed?

29 MR. MOISLEY: No, nothing to do with it
30 whatever, sir.



1 MR. MACLEOD: How did you think that the
2 association with Honest Ed's operation would be undesirable
3 from the point of view of the pharmacy?

4 MR. MOISLEY: Well, one of the things I was
5 concerned with in examining the lease, were the monetary
6 arrangements for the amount of space. I was concerned
7 with the control of the business, of the professional
8 aspect of the business.

9 MR. MACLEOD: Are you saying that you would
10 have had no objection provided a fixed rental had been
11 stipulated in the lease?

12 MR. MOISLEY: No.

13 MR. MACLEOD: Well, that is what I am trying
14 to get at, the other grounds of your objection.

15 MR. MOISLEY: A large rental for a very
16 small space would indicate to me that someone beside Mr.
17 Englisher had an interest in it.

18 MR. MACLEOD: But your technical objection,
19 and I don't use that in any derogatory sense, your techni-
20 cal objection was that the rental as stipulated was a
21 percentage of gross intake, wasn't it?

22 MR. MOISLEY: No, it was not, sir. Not
23 totally.

24 MR. MACLEOD: No, but wasn't your objec-
25 tion the fact that the rental was tied in as a percentage
26 of sales, which in effect meant that the lessor has some-
27 thing in the nature of a proprietary interest in the
28 business?

29 MR. MOISLEY: That was it exactly. Proprie-
30 tory interest.



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Moisley

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1 MR. MACLEOD: I am asking you would your
2 objection have disappeared if a fixed rental had been
3 quoted?

4 MR. MOISLEY: Not totally.

5 MR. MACLEOD: Were there other factors
6 besides this proprietary interest, which to your mind
7 made it undesirable for a drugstore to be operated in
8 that location?

9 MR. MOISLEY: Let's put it this way, Mr.
10 MacLeod, the type of operation.

11 MR. MACLEOD: In your view this was not a
12 proper environment for a drugstore?

13 MR. MOISLEY: That is correct, and still is,
14 may I add.

15 MR. MACLEOD: Pardon?

16 MR. MOISLEY: And still is, may I add.

17 THE CHAIRMAN: You mean the type of Honest
18 Ed's operation or the type of operation in the pharmacy
19 in Honest Ed's?

20 MR. MOISLEY: The type of Honest Ed's opera-
21 tion.

22 MR. MACLEOD: Do you regard the Director's
23 comment in the very last sentence of paragraph 157 on
24 page 92 as accurate? The sentence reads: "However, it is
25 clear that, among individual druggists, the opposition to
26 Mr. Englander arose because of his pricing policies".

27 MR. MOISLEY: What paragraph, Mr. MacLeod?

28 MR. MACLEOD: 157 on page 92, the last
29 sentence.

30 MR. MOISLEY: Well, Mr. MacLeod, I don't



1 think I can speak for individual druggists. They are
2 entitled to their opinion. I am entitled to mine.

3 MR. MACLEOD: Did you not have communications
4 from a number of individual druggists?

5 MR. MOISLEY: Not while this was going on,
6 no. We did have communications from pharmacists regarding
7 it, but not previous to my involvement.

8 MR. MACLEOD: Well, was there no opposition
9 among druggists to the starting of the store in this loca-
10 tion which came to your attention before your decision?

11 MR. MOISLEY: Well, I would have to check
12 back on files, Mr. MacLeod, to answer that truly and in
13 detail, but I can tell you that those opinions had no
14 bearing on mine. They just couldn't have.

15 MR. MACLEOD: Didn't you in fact poll all
16 the members of the Council?

17 MR. MOISLEY: Yes.

18 MR. MACLEOD: And did that poll have any
19 bearing on your decision?

20 MR. MOISLEY: That was merely Council's
21 instructions to me. They were upholding the way I had
22 handled the case. That was all I wanted there.

23 MR. MACLEOD: Didn't you in fact poll them
24 before you issued your decision?

25 MR. MOISLEY: Yes.

26 MR. MACLEOD: And wasn't your decision
27 based in part at least on the poll?

28 MR. MOISLEY: No. My mind was made up
29 previous to that.

30 MR. MACLEOD: What was the purpose of taking



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1 a poll?

2 MR. MOISLEY: Just to see that I had the
3 support from council.

4 MR. MacLEOD: Just to get the record straight,
5 didn't you in fact make an interim decision or make a
6 statement that you would not issue your decision until you
7 had a chance to discuss it with council?

8 MR. MOISLEY: Not discuss it, I don't
9 believe, Mr. MacLeod. I had the poll.

10 MR. MacLEOD: Didn't you in fact state that
11 you would not make a decision until you had a chance to
12 refer this matter to council?

13 MR. MOISLEY: Oh, yes, certainly.

14 MR. MacLEOD: And council of course would
15 all be practising pharmacists?

16 MR. MOISLEY: That is right.

17 MR. MacLEOD: With the exception possibly
18 of any academic ex officio members?

19 MR. MOISLEY: That is right.

20 MR. MacLEOD: I think those are all the
21 questions. As I indicated, I would like to get an answer
22 to certain commercial questions about pricing prescriptions
23 and so on.

24 THE CHAIRMAN: I was just wondering if we
25 should pursue this matter any further, what part of the
26 operation at Honest Ed's you objected to, not because of
27 the discount house? What are the things about the operation
28 that you dislike?
29 -
30 -



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Moisley

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1 R/hm
2 MR. MOISLEY: Well I can only say it in
3 generalities Mr. Chairman. Let's put it this way: As
4 a pharmacist it does not appeal to me to be a place where
I would want to have my own store, my own dispensary.

5 THE CHAIRMAN: Well I wonder if there aren't
6 some other pharmacies about which you may make the same
7 comment?

8 MR. MOISLEY: I think possibly there are.

9 THE CHAIRMAN: Thank you then, Mr. Moisley,
10 unless Mr. Isbister wishes to ask you any questions?

11 MR. ISBISTER: No, I do not, thank you.

12 Now, Mr. Chairman, as I indicated earlier Mr. Isaacson is
13 here. For some four years he was Chairman of the Prescrip-
14 tion Pricing Committee. The exhibits are before you and
15 as I told you earlier, he is also a member of Council.

16 I have personally no specific questions to
17 put to him. I think that the Commission, you sir, or
18 Mr. MacLeod will have questions and Mr. Isaacson is here
19 to answer them as best he can.

20

21 MR. W. ISAACSON, Called

22

23 THE CHAIRMAN: You have some questions I
24 believe Mr. Frawley?

25 MR. FRAWLEY: Yes, shall I go first? Mr.
26 Isaacson, you are the proprietor of a retail pharmacy?

27 MR. ISAACSON: Yes sir.

28 MR. FRAWLEY: Carrying on business in Toronto?

29 MR. ISAACSON: Yes.

30 MR. FRAWLEY: What is the name of your drug



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1 store?

2 MR. ISAACSON: Well, I am associated with
3 several Mr. Frawley. I can give you one name if you like.

4 MR. FRAWLEY: Just give me a name.

5 MR. ISAACSON: Lawrence Park.

6 MR. FRAWLEY: Give me your best and biggest
7 one.

8 MR. ISAACSON: That is not the biggest one
9 but it is an ordinary type of drug store on Yonge Street.
10 Lawrence Park Pharmacy.

11 MR. FRAWLEY: On Yonge Street?

12 MR. ISAACSON: On Yonge Street.

13 MR. FRAWLEY: And you have a dispensary
14 there?

15 MR. ISAACSON: Yes.

16 MR. FRAWLEY: And you also, I suppose, own
17 one of these 22nd edition May 1961 price books put out
18 by the Canadian Pharmaceutical Association?

19 MR. ISAACSON: Yes.

20 MR. FRAWLEY: And is this generally what
21 you use in pricing the articles in your pharmacy?

22 MR. ISAACSON: We find it very handy for
23 reference purposes.

24 MR. FRAWLEY: It seems to omit nothing at
25 all, as I read it through. Now that being what you follow
26 as a guide would you be kind enough to tell me then, Mr.
27 Isaacson, do you sell Ayerst Miltown at \$5.00 for 50
28 tablets?

29 MR. ISAACSON: Yes.

30 MR. FRAWLEY: And you sell that product



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1 at \$43.75 for 500 tablets?

2 MR. ISAACSON: Whether we buy it in 500?

3 MR. FRAWLEY: No, these are list prices.

4 I said sell. You sell 50 tablets at \$5.00?

5 MR. ISAACSON: Actually if it was a pres-
6 cription, which it would be, we would take the pricing
7 guide and it would be \$5.75.

8 MR. FRAWLEY: It would be \$5.00 plus 75¢
9 prescription fee?

10 MR. ISAACSON: Yes.

11 MR. FRAWLEY: We will leave the 500. I
12 suppose you find people coming in with a prescription for
13 500 Miltown tablets? No?

14 MR. ISAACSON: No.

15 MR. FRAWLEY: You buy it in 500 and perhaps
16 break it up?

17 MR. ISAACSON: No, it comes in these
18 original little containers of 50 and we might buy a quarter
19 of a dozen, or half a dozen.

20 MR. FRAWLEY: If you had a prescription for
21 25, what would the price be at \$5.00 for 50?

22 MR. ISAACSON: We would follow -- I would
23 follow the pricing guide and on the list at \$5.00 for 50,
24 or a half, then it comes out half of 50 it would be
25 \$3.75

26 MR. FRAWLEY: It would be \$3.75?

27 MR. ISAACSON: Right.

28 MR. FRAWLEY: It would be \$2.50 plus \$1.25
29 prescription fee?

30 MR. ISAACSON: Well now, we would have to



1 break it down - as to how we arrive at that.

2 MR. FRAWLEY: I don't know, perhaps it is
3 my arithmetic.

4 THE CHAIRMAN: I think, Mr. Frawley, he
5 needs to break it down. When they break them they don't
6 always just take a proportion.

7 MR. FRAWLEY: That is what I am coming to.
8 If you sold the original package unbroken to fill a
9 prescription -- you filled a prescription with the
10 original package unbroken you would fill it for \$5.00
11 and 75¢ prescription fee.

12 MR. ISAACSON: That is correct.

13 MR. FRAWLEY: If the prescription called
14 for 25 then you would have to open a bottle of 50?

15 MR. ISAACSON: Yes.

16 MR. FRAWLEY: Then how much would you charge
17 for the tablets?

18 MR. ISAACSON: Well, if we had to calculate
19 it, if we did not have this, I would calculate it out at
20 60% of the \$5.00 which would be \$3.00 plus 75¢ dispensing
21 fee

22 MR. FRAWLEY: I understand the manner in
23 which you calculate. It is something more than just
24 a straight half when you break a bottle?

25 MR. ISAACSON: For breakage, yes.

26 MR. FRAWLEY: This will just take a few
27 minutes Mr. Isaacson: For a prescription for 16 of
28 Lederle Declomycin in capsules of 150 mgm dosage you would
29 charge \$7.90?

30 MR. ISAACSON: Yes.



1 MR. FRAWLEY: Plus a prescription fee of
2 what?

3 MR. ISAACSON: Well now, that varies again.
4 As I say, we take a lot of leeway in those high priced
5 drugs. I believe I could say every pharmacy does and if
6 I felt that \$7.90 was enough I would not even charge a 75¢ fee. I
7 would not say that it would be same in every case, but where I
8 feel, in my judgment I don't want to take the fee, I would
9 just charge \$7.90.

10 THE CHAIRMAN: You mean your price for the
11 same prescription might vary as between customers?

12 MR. ISAACSON: Well, it would become a policy
13 of the store for a high priced drug not to add on the fee.

14 THE CHAIRMAN: Is that your policy on high
15 priced drugs?

16 MR. ISAACSON: I don't want to be pinned
17 down that it would be in every single case, but usually.

18 MR. FRAWLEY: I certainly do not want to
19 be critical of your method of assessing or charging your
20 professional fee but as you told it now to me in the high
21 priced drugs there may be a point where the recommended
22 prescription is not charged at all?

23 MR. ISAACSON: Yes.

24 MR. FRAWLEY: But in the lower priced drug
25 you would charge the prescription fee called for by the
schedule?

27 MR. ISAACSON: In the lower priced drugs
28 from that figure, that is, the \$7.00 -- \$8.00 range down.

29 MR. FRAWLEY: Does the prescription fee
30 vary? Is it always 75¢ or does it run higher than that or



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1 lower?

2 MR. ISAACSON: Again discussing the pricing
3 guide, the 75¢ fee is built into practically all these
4 prices.

5 MR. FRAWLEY: Just generally speaking do
6 you very often charge a \$1.00 prescription fee?

7 MR. ISAACSON: No.

8 MR. FRAWLEY: Have you ever charged a \$1.25
9 prescription fee?

10 MR. ISAACSON: If it were following this
11 guide there would be no need to be concerned with whether
12 it is \$1.25 or \$1.00 or 75¢ or 50¢. There are some in
13 this booklet where it shows only a 50¢ dispensing fee on
14 top of the price.

15 MR. FRAWLEY: All right, just let me run
16 quickly through some of these with you. For a prescription
17 of 16 Polycycline tablets of Bristol, 250 mgm dosage you
18 would charge \$7.90?

19 MR. ISAACSON: If that was the price that
20 we got from the manufacturer.

21 MR. FRAWLEY: That is the list?

22 MR. ISAACSON: It might be -- we might use
23 that book if we did not have the price marked on the
24 container or on the package itself. When it comes into
25 the store it is usually checked with an invoice and if the
26 invoice has the price on it, we immediately transfer that
27 price to the package and then it is put on the shelf.

28 MR. FRAWLEY: Well now, I certainly want to
29 be clear about this

30 MR. ISAACSON: We may not always look at the



1 price book.

2 MR. FRAWLEY: You take it from me, without
3 going through this, that the price list from and after
4 May 1961 was \$7.90 and is \$7.90 in 16's, 250 mgm dosage
5 of Bristol's Polycycline capsules. Now, do I understand
6 that you would or would not charge \$7.90?

7 MR. ISAACSON: Again, Mr. Frawley, I would
8 say this: Since May, if since May since that price book
9 was published, the price of Polycycline came down then
10 our package, our shelf package would be priced at a lower
11 price than what is in that book. That is why we would
12 refer first of all to the price we have marked on the
13 package itself.

14 It could be lower and therefore we would
15 follow the lower price.

16 MR. FRAWLEY: What could be lower?

17 MR. ISAACSON: When the manufacturer
18 reduces his price -- and this is happening all the time --
19 when a price reduction comes in from the manufacturer on
20 any of these products, we automatically reduce the price
21 and pass that on to the customer.

22 MR. FRAWLEY: Would this help you at all,
23 Mr. Isaacson. I find from looking at the two price lists,
24 the 21st edition which bears date November 1960 and the
25 22nd edition dated May 1961 -- in the 21st edition the
26 price of these capsules was \$9.44 for 16 and in the May
27 1961 catalogue was reduced to \$7.90.

28 MR. ISAACSON: That is right.

29 MR. FRAWLEY: Well now, do you suggest
30 that it may be, and I don't know, you would know that since



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1 May 1961, within the last four or five months that those
2 Bristol capsules have come down again below \$7.90?

3 MR. ISAACSON: I am not quite sure of that
4 particular capsule but it is possible.

5 MR. ISBISTER: He didn't suggest that they
6 have. He said if they have.

7 MR. FRAWLEY: I am only concerned with the
8 pricing methods. So if it has come down today actually
9 and you are being invoiced for these capsules at -- well,
10 take any figure \$6.00 -- then it is \$6.00 that you would
11 charge?

12 MR. ISAACSON: That is right.

13 MR. FRAWLEY: And if the list price is still
14 \$7.90 then you charge \$7.90?

15 MR. ISAACSON: Yes.

16 MR. FRAWLEY: We understand each other.
17 Well now, as to the prescription fee: You would add or
18 would not add a prescription fee to these Polycycline
19 tablets?

20 MR. ISAACSON: If it was \$7.90 it would
21 be \$8.55. We would add the dispensing fee on.

22 MR. FRAWLEY: You would add it on?

23 MR. ISAACSON: But again we would decide
24 that for ourselves. We have freedom of action here, Mr.
25 Frawley. If we feel we do not want to add on a 75¢ fee
26 we don't add it on.

27 MR. FRAWLEY: In other words, your remarks
28 with respect to Polycycline capsules at \$7.90 are the same
29 as you gave me when you were talking about Lederle's
30 Declomycin capsules at \$7.90?



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1 MR. ISAACSON: Yes.

2 MR. FRAWLEY: The same situation?

3 MR. ISAACSON: Yes.

4 MR. FRAWLEY: As to the adding on or not
5 adding on of the whole or part of the prescription fee?

6 MR. ISAACSON: Yes.

7 MR. FRAWLEY: Now, if you had a prescription
8 for 25 of Lederle's Aureomycin capsules at 50 mgm dosage
9 you would charge \$3.00?

10 MR. ISAACSON: If that is the list price.
11 I am not too familiar with all the prices.

12 MR. FRAWLEY: That is right. If you will
13 take it from me as a result of a lot of labour I have
14 dug it out of this book and it is \$3.00.

15 MR. ISAACSON: That is the list price?

16 MR. FRAWLEY: That is the list price for
17 25.

18 MR. ISAACSON: So our list price is \$3.00,
19 it would be \$3.75.

20 MR. FRAWLEY: Now just let me ask you one
21 or two more. A prescription for Parke Davis' Chloromycetin
22 in 250 mgm dosage you would charge \$6.60 for 16?

23 MR. ISAACSON: Yes.

24 MR. FRAWLEY: And that I may say was \$9.45
25 in the old -- in the prior price list and came down to
26 \$6.60 and you would charge that plus -- if you plussed it
27 all -- a prescription fee and would you at the \$6.60
28 range, would you be likely to add a prescription fee?

29 MR. ISAACSON: As I say it hasn't been a
30 hard and fast rule.



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1 MR. FRAWLEY: The cut off place is vague
2 and uncertain?

3 MR. ISAACSON: Yes.

4 MR. FRAWLEY: But at some point you make
5 a judgment as to whether you will add the prescription
6 fee or not?

7 MR. ISAACSON: Yes.

8 MR. FRAWLEY: And let me ask you about
9 Lederle's Achromycin 250 mgm dosage. Now would you charge
10 \$7.90 for 16?

11 MR. ISAACSON: Yes.

12 MR. FRAWLEY: Except this, that I should say
13 this to you: Mr. Thompson of the Cyanamid Company gave
14 evidence and the brief indicated that his price now was
15 \$43.13 for 100 although the last price list that was filed
16 says \$47.88.

17

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1 MR. FRAWLEY: If Squibb has reduced its
2 price you receive some follow-up material from the
3 publishers of the price book, I suppose?

4 MR. ISAACSON: No, I think what we would
5 do is look up the price book and enter the reduced price
6 and strike out the old price.

7 MR. FRAWLEY: Guided by your invoice, in
8 other words?

9 MR. ISAACSON: Yes.

10 MR. FRAWLEY: I am sorry, Mr. Chairman,
11 I would like to get on the record in this place, because
12 this is the first retail pharmacist we have seen and I
13 would certainly like the indulgence of the Commission for
14 a few moments. Mr. Isaacson, if you have Poulenc's
15 Largactil for 20 you would have \$2.50.

16 MR. ISAACSON: That is list?

17 MR. FRAWLEY: That is list.

18 MR. ISAACSON: \$2.50 plus 75¢.

19 MR. FRAWLEY: Plus 75. If you had a
20 prescription that is -- that is 25 mgm dosage -- if you
21 had a prescription calling for 100, which may or may not
22 be likely, you would charge \$10.50?

23 MR. ISAACSON: That is the list? If
24 \$10.50 is the list we would charge list.

25 MR. FRAWLEY: Without ---?

26 MR. ISAACSON: Without a dispensing fee.

27 MR. FRAWLEY: Now, if you had a prescription
28 for Tetracycline, which is one of those things we have
29 talked about a great deal here, for Tetracycline by generic
30 name -- if you received a prescription of that sort would



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1 you be able to fill it in your Lawrence Park drug store?

2 MR. ISAACSON: Yes.

3 MR. FRAWLEY: Because you do carry a product
4 that is called Empire Tetracycline.

5 MR. ISAACSON: We would probably if it was
6 being dispensed, if the prescriptions were coming. Maybe
7 the first prescription -- sometimes we don't have all
8 these various products, their different forms, but we
9 would get it.

10 MR. FRAWLEY: Let me discuss that with you
11 a little. You would get it. You wouldn't turn your
12 customer away, you would say I will get it for you.

13 MR. ISAACSON: If it has to be Empire.

14 MR. FRAWLEY: Empire is the only one I
15 find that is listed in the Canadian Pharmaceutical price
16 list.

17 MR. ISAACSON: There are many.

18 MR. FRAWLEY: Empire Tetracycline in the
19 list for 250 mgm, \$9.80 for 32. You would charge that
20 list price with a prescription fee or, probably not?

21 MR. ISAACSON: \$9.80, I think we would
22 charge just the list price.

23 THE CHAIRMAN: Perhaps there should be
24 another question. If the prescription calls for Tetra-
25 cycline without specifying it should be Empire's or any
26 particular company, what would you supply?

27 MR. ISAACSON: Normally, Mr. Chairman,
28 we would have some well-known products. It might be
29 Bristol or it might be one of the others. If we had
30 that in stock this is what we would dispense unless we felt



1 that the doctor specifically wanted the cheap or lower
2 priced brand -- let us not call it cheap, lower priced
3 product, then we would check with the doctor to make sure.
4 If he wanted the lower priced one we would get it. He
5 would probably ask us what we had and we would tell him
6 and he would make the decision. If it was the choice
7 between one or the other.

8 THE CHAIRMAN: If the prescription has
9 only got what is actually called the generic name or
10 proper name you would normally sell that with one of the
11 manufacturers who made a trade name? As long as it is
12 the product that is prescribed you would sell it from one
13 of these.

14 MR. ISAACSON: As long as we were satisfied
15 it was of good quality.

16 MR. FRAWLEY: If you received a prescription
17 which is simply Tetracycline, 250 mgm Tetracycline would
18 you think, first of all, of selling it with Bristol's
19 Tetracycline which is 250 mgm Tetracycline.

20 MR. ISAACSON: We wouldn't infer that the
21 doctor meant a lower priced one just because he wrote it
22 in the generic name because many doctors write in the
23 generic language regardless of what.

24 MR. FRAWLEY: That is something I would
25 like to discuss with you. If you received a prescription
26 in the generic name would you automatically go to your
27 brand name Tetracyclines and fill it with that and charge
28 accordingly?

29 MR. ISAACSON: In other words we would go
30 to the shelf and dispense it from one of the products.



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1 There may be more than one of them.

2 MR. FRAWLEY: From one of the brand named
3 Tetracyclines?

4 MR. ISAACSON: Yes.

5 MR. FRAWLEY: Like Lederle's Achromycin?

6 MR. ISBISTER: He didn't say brand name,
7 he said one of the products on the shelf. It might be
8 something else.

9 MR. FRAWLEY: If you received a prescription
10 for Tetracycline, which I understand should be Tetracycline
11 Hydrochloride, but Tetracycline and all you had were the
12 brand name Tetracyclines which I put to you, among others
13 would be Lederle's Achromycin, Bristol's Polycycline,
14 Pfizer's Tetracycline and Squibb's Steclin. Would you fill
15 this prescription written by generic name with one of the
16 trade names and consider that is all that is needed to
17 be done?

18 MR. ISAACSON: Again, I would have to
19 state this is an unusual practice. The doctors usually
20 specify the name of the manufacturer whether they write
21 in the generic name or use the brand name.

22 MR. FRAWLEY: I am speaking about a situation
23 written for Tetracycline, not Bristol's Polycycline or
24 Lederle's Achromycin -- just written Tetracycline, nothing
25 else. Would you not regard that as a prescription to
26 be filled by a generic drug and not a brand name drug?

27 MR. ISAACSON: You mean that I might think
28 of using a much lower priced drug of the generic type?

29 MR. FRAWLEY: If the generic is lower. I
30 put it to you, Mr. Isaacson, you should then think this



1 doctor didn't want one of the brand names, but he wanted
2 you to fill the prescription with a generic name.

3 MR. ISAACSON: I wouldn't be sure. I would
4 have to check with the doctor.

5 MR. FRAWLEY: That is what I want to know:
6 If you received a prescription of the kind I am speaking
7 of you would check back with the doctor and find out if
8 he really meant to prescribe one of the four or five
9 well-known tetracyclines or whether he wished you to fill
10 it with whatever generic tetracycline you might have on
11 your shelves or not.

12 MR. ISAACSON: Yes.

13 MR. FRAWLEY: If he said he wanted the
14 generic tetracycline then you would get it?

15 MR. ISAACSON: Yes.

16 MR. FRAWLEY: Does that apply to other
17 cases? There is no point in going through all the generics.
18 It would apply to all prescriptions you would receive
19 written in generic names?

20 MR. ISAACSON: Yes.

21 MR. FRAWLEY: If you received a prescription
22 for Meprobamate 500 mgm Meprobamate would you fill that
23 with the Meprobamate of Empire which is listed in this
24 price book or would you fill it with one of the very well-
25 known Meprobamates, Ayerst's Miltown or Wyeth's Equinol?

26 THE CHAIRMAN: If the doctor hadn't written
27 it?

28 MR. ISAACSON: Empire, we certainly wouldn't
29 use Empire unless he wrote Empire on it. With Empire's
30 name on it it becomes a brand name too.



1 MR. FRAWLEY: If there was no name, just
2 meprobamate, 400 mgm, 100 tablets or whatever the amount
3 would be, then what would you fill it with?

4 MR. ISAACSON: I would go to our shelf and
5 if we felt there was no question about it -- again,
6 assuming we didn't have to call the doctor -- these are
7 exceptional cases. I have never sold a prescription
8 without being absolutely sure what the doctor ordered. We
9 must make sure before we fill it. I don't assume anything.
10 I would make sure what the doctor wants before I would
11 fill it.

12 MR. FRAWLEY: On the meprobamate, I find
13 the list price for 400 mgm, you would sell that to the
14 patient for \$1.80. Let me check myself about that.
15 \$1.80 for a hundred meprobamates, 400 mgm, Empire's. If
16 you filled it with Equanil you would charge \$5.00 for 50.
17 You receive \$5.00 for 50 without your prescription fee if
18 you decide to charge it?

19 MR. ISAACSON: That is correct.

20 MR. FRAWLEY: There certainly is that money
21 difference between the two transactions; isn't there?

22 MR. ISAACSON: Yes.

23 MR. FRAWLEY: What you say is for your own
24 security you would check back with the doctor if you
25 received a prescription as simply meprobamate with nothing
26 else added?

27 MR. ISAACSON: Yes.

28 MR. FRAWLEY: You wouldn't feel you could
29 fill that prescription with Empire's Meprobamate or
30 Gilbert's Meprobamate or Starkman's or anybody else that



1 sell meprobamate by its generic name?

2 MR. ISAACSON: I wouldn't know whether the
3 doctor had Empire in mind or Gilbert or anyone else.

4 MR. FRAWLEY: If he didn't have anybody
5 else in mind and simply left it to you to dispense the
6 proper meprobamate

7 MR. ISAACSON: Quality would be my first
8 consideration.

9 MR. FRAWLEY: You do agree with me if you
10 decided finally, with or without the doctor's concurrence
11 that you were going to fill it with Wyeth's Equinol that
12 would make a difference in price to the patient?

13 MR. ISAACSON: A big difference.

14 MR. FRAWLEY: Do you sometimes dispense
15 Squibb's Vesparin?

16 MR. ISAACSON: Yes.

17 MR. FRAWLEY: I put it to you, if you do,
18 you would charge for a 25 mgm dosage of Vesparin \$1.75
19 if you dispensed it in 50's probably with a prescription
20 fee added?

21 THE CHAIRMAN: Did you say yes?

22 MR. ISAACSON: Yes.

23 MR. FRAWLEY: Do you know from your knowledge
24 of the drug business and I am just limiting myself to the
25 filling of prescriptions for broad spectrum antibiotics,
26 tranquilizers and corticosteroids, can you tell me whether
27 or not there is or is not a large degree of conformity to
28 the price list when charging -- when filling prescriptions
29 for these drugs?

30 MR. ISBISTER: Mr. Chairman, I think my



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1 friend wants this witness to give one of two answers,
2 either what he knows, or what he would hear up and down
3 the street, to put it colloquially, latrine rumours. The
4 witness is asked what do you know about this, are
5 schedules followed. I think in fairness to the witness
6 it should be made clear to him he is not going to help
7 this Commission by giving you, as I say, what would be
8 heard by rumour. If he has made some investigation, if
9 he is properly informed -- he ought not to be asked
10 to give his opinion on what is said in the street.

11 THE CHAIRMAN: I think he is being asked
12 as chairman of the Prescription Pricing Committee.

13 MR. ISBISTER: I want that made clear.

14 THE CHAIRMAN: If the witness can answer
15 the question from information that he has in his possession
16 he ought to do so.

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1 MR. FRAWLEY: It seems to me actually,
2 rather than being an ordinary witness he is far from an
3 ordinary witness. We are fortunate enough to have a man
4 who has an interest in five or six drugstores.

5 From your knowledge of the retail pharmacy
6 business in Toronto, you have told me what prices you were
7 to charge normally, list price plus a prescription fee,
8 and I simply ask you whether or not to your knowledge
9 that is the general picture among pharmacists in Toronto?

10 MR. ISAACSON: If I might, Mr. Frawley, just
11 stick to the sources that I am associated with, there is
12 a variation between those stores in these prices.

13 MR. FRAWLEY: What variation would there be?
14 Could you point out the variation there would be? Are
15 any of your stores selling Bristol's Polycycline at some-
16 thing less or more than \$7.90 for 16?

17 MR. ISAACSON: It would be less. It would
18 never be any more.

19 MR. FRAWLEY: It would never be any more?

20 MR. ISAACSON: Because that is only used as a
21 guide.

22 MR. FRAWLEY: What would be the variation?

23 MR. ISAACSON: It would be 10% or 15%.

24 MR. FRAWLEY: In other words, some of your
25 stores are satisfied at making a price judgment to take
26 less than the 40% discount allowed by the manufacturer?

27 MR. ISAACSON: No, the answer to that, Mr.
28 Frawley, would be depending on the area and the competition.
29 There is a lot of competition between pharmacists in
30 prices.



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1 MR. FRAWLEY: For these drugs that I am
2 concerned about?

3 MR. ISAACSON: For every prescription, and
4 in different areas it is much more, what shall I say,
5 more intense. Whereas in the other areas such as highly
6 residential, high income brackets, there is not that type
7 of competition. You don't find this price cutting, as it
8 is called, as much.

9 MR. FRAWLEY: That is very interesting. In
10 other words if I had a prescription for 16 of Lederle's
11 Declomycin capsules and I had the time and the inclination
12 to go to each one of your five stores, I would find - just
13 what differences would I find in different stores if I
14 offered the prescription and said, "How much will you
15 charge me?" People sometimes do that with prescriptions?

16 MR. ISAACSON: Oh yes.

17 MR. FRAWLEY: I didn't know that. What
18 would I find? What would be my experience with my pres-
19 cription for 16 Declomycin capsules?

20 MR. ISAACSON: It is left to the manager of
21 that store, the pharmacist in charge.

22 MR. FRAWLEY: But you have an interest in
23 these stores and I just want to get an idea of what range
24 there would be. In Lawrence Park it would be \$7.90,
25 would it?

26 MR. ISAACSON: It would be 50¢ less.

27 MR. FRAWLEY: It would be 50¢ less in some
28 of the stores?

29 MR. ISAACSON: If it was a \$7 or \$8 item.

30 MR. FRAWLEY: I am talking about \$7.90.



1 MR. ISAACSON: Yes, it would be 50¢ less.

2 MR. FRAWLEY: Mr. Isaacson, there is some-
3 thing else I would like to ask you. Do you buy your
4 drugs from the manufacturer or from the wholesaler?

5 MR. ISAACSON: From both.

6 MR. FRAWLEY: Some from the wholesaler and
7 some from the manufacturer?

8 MR. ISAACSON: Whichever is more convenient.

9 MR. FRAWLEY: What is the pricing situation?
10 If you wanted, how do you buy, let us take any one of them
11 at all. Take Lederle's Declomycin capsules, how do you
12 generally buy that, in one dozen bottles of 16, or some-
13 thing of that sort?

14 MR. ISAACSON: No, again it depends upon
15 the turnover of the prescriptions. Some of the stores
16 may only carry one bottle on the shelf, if they think
17 that is enough, and other stores, depending again on the
18 turnover of that particular item, might buy two or three.
19 But generally not too many are bought because it ties up
20 a lot of money. They are high-priced, and it has to sit
21 on the shelf sometimes for a while before it can be dis-
22 pensed.

23 MR. FRAWLEY: Well now, do you buy that
24 from an advertisement, from a price list or just what are
25 the mechanics of the buying of that? Do you telephone in
26 an order?

27 MR. ISAACSON: Yes, usually it is 'phoned.
28 Let us say this, if we are buying from the manufacturer,
29 direct from him, and many of these drugs are bought
30 directly from Parke-Davis, Squibb and Lederle, and if



1 there is a local office, we 'phone in an order. If it is
2 out of town, we will have to mail it.

3 MR. FRAWLEY: And the price comes in and
4 you are invoiced at the list price less 40%?

5 MR. ISAACSON: It varies. They are not
6 all 40. Some are only a third.

7 MR. FRAWLEY: Are any ever more than 40?

8 MR. ISAACSON: No, not very often.

9 MR. FRAWLEY: You buy at the list less a
10 discount?

11 MR. ISAACSON: Yes.

12 MR. FRAWLEY: You don't actually pay for
13 goods valued at one dollar - it doesn't come in, invoiced
14 at 60¢, but it comes in listed at \$1 less 40%?

15 MR. ISAACSON: Again I must point out, Mr.
16 Frawley, that there are invoices coming in now more than
17 previously at the net price, no list mentioned, and no
18 discount.

19 MR. FRAWLEY: You know that it is something
20 off the list as soon as you look at it.

21 MR. ISAACSON: Yes, but many invoices are
22 coming in, and I think Lederle is one of them, that just
23 show the net price for each item.

24 MR. FRAWLEY: What I am getting at, Mr.
25 Isaacson, is I would like to know to what extent you ever
26 bargain with your supplier for a better price of these
27 prescription drugs, and I am limiting myself again to the
28 three I mentioned?

29 MR. ISAACSON: There is no bargaining.

30 Somehow to us these particular products, or even any of



1 these products, any products we might see in the drugstore,
2 do not lend themselves to bargaining.

3 MR. FRAWLEY: In other words without using
4 the word offensively, you are a captive market for the
5 manufacturer of its higher cost drugs?

6 THE CHAIRMAN: The answer is "yes"?

7 MR. ISAACSON: Yes.

8 MR. FRAWLEY: From what you have just told
9 me, you are really more captive even than the patient is
10 even captive of the pharmacist.

11 MR. ISAACSON: We cannot question the price
12 which the manufacturer charges us for his product.

13 MR. FRAWLEY: And you don't question it and
14 you pay the manufacturer's price?

15 MR. ISAACSON: Whatever he charges.

16 MR. FRAWLEY: But you are telling me now,
17 this morning, sometimes in some sections of the city a
18 patient with a prescription can get a better price than a
19 patient with a prescription, up in Lawrence Park, for
20 instance. Is Lawrence Park one of the better parts of
21 Toronto?

22 MR. ISAACSON: Yes.

23 MR. FRAWLEY: So that if you take your
24 prescription into Lawrence Park, you are not going to get
25 any bargain, but if you take your prescription down in
26 what we used to call when I was at law school "The ward",
27 perhaps it is gone now, you might do a little better.

28 MR. ISAACSON: I would answer it this way,
29 Mr. Frawley, we only make so much. Let us talk about
30 list. If I make 40% from the manufacturer and no more,



1 I need that 40% as a rule for my overhead, but if I am in
2 a competitive area where I might lose a lot of business
3 by trying to get my 40%, I feel I will take less profit
4 and just take so much for my profit. It doesn't mean I
5 can buy it any cheaper from the manufacturer.

6 MR. FRAWLEY: No, you have to take up that
7 shrinkage.

8 MR. ISAACSON: Yes.

9 MR. FRAWLEY: That is interesting in the
10 light of what Mr. Turnbull said to us. He said the
11 Association was thinking about and looking forward to a
12 bigger discount. They want to get the 40% up to 50%.

13 MR. ISAACSON: I have not heard about it.

14 MR. FRAWLEY: You have not heard about it?

15 MR. ISAACSON: I am not even interested in
16 it.

17 MR. FRAWLEY: But notwithstanding the fact
18 that the Association thinks that 40% is certainly minimum
19 and it should go to 50, you say in some areas of Toronto
20 40 has to be shrunk to 30?

21 MR. ISBISTER: That is what he said quite
22 some time ago.

23 MR. FRAWLEY: Thank you very much.

24 THE CHAIRMAN: Will you be some time, Mr.
25 MacLeod? It is our usual time to adjourn.

26 MR. MACLEOD: I think I can be fairly short,
27 sir.

28 THE CHAIRMAN: Do you mean five minutes or
29 so?

30 MR. MACLEOD: Not very much longer.



1 THE CHAIRMAN: I know Mr. Isbister has an
2 appointment.

3 MR. ISBISTER: I can wait for a few minutes
4 if that is all it will be.

5 THE CHAIRMAN: Well we might as well finish
6 in that case.

7 MR. MACLEOD: Do you have a copy of the
8 pricing guide which was Exhibit T-22 in front of you?

9 MR. ISAACSON: Yes sir.

10 MR. MACLEOD: Will you tell me the price
11 set out in the guide for 50 tablets which come in a 100-
12 tablet bottle, the list price of which is \$10.50?

13 MR. ISAACSON: Well, there is no \$10.50
14 here. There is \$10.40 and \$10.60. I would take the
15 \$10.40 for 50 which would be \$6.75.

16 MR. MACLEOD: And if someone else took the
17 \$10.60?

18 MR. ISAACSON: It would be 10¢ more.

19 MR. MACLEOD: Did your committee make any
20 recommendation as to which figure to use when it adopted
21 the practice of setting up prices in multiples of 20¢ and
22 10¢?

23 MR. ISAACSON: No, we left it to the discre-
24 tion of the pharmacists.

25 MR. MACLEOD: So if it comes half-way
26 between, the pharmacist may use either.

27 MR. ISAACSON: I may point out, Mr. MacLeod,
28 No. 8 on page 5:

29 "In cases where a discrepancy exists between
30 original 4-ounce bottles and the pour-out



1 from 16-ounce bottles, use the unit which
2 will be more favourable to the patient".

3 In other words, the lower price is what we
4 would recommend to the pharmacist, but he still has to
5 use his own discretion.

6 MR. MACLEOD: Assuming the product was not
7 a prescription product and you had to break a 100-tablet
8 bottle to give the patient 50 tablets, and the list price
9 of the 100-tablet bottle was \$10.50, what would you charge
10 for 50 in that case?

11 MR. ISAACSON: If it was not a prescription?

12 MR. MACLEOD: If it was not a prescription.

13 MR. ISAACSON: We would not break it.

14 MR. MACLEOD: You would not break it?

15 MR. ISAACSON: No, we don't know if we would
16 be ever able to use the other half if we had to take half
17 of it. Over the counter you sell original packages provi-
18 ding it is an item that you can sell without a prescription.

19 MR. MACLEOD: You told Mr. Frawley that it
20 was becoming increasingly common for manufacturers to
21 invoice at a net price. Do you have any rule about esta-
22 blishing the resale price in this case?

23 MR. ISAACSON: I think each pharmacist has
24 to use his own judgment, because he cannot use this. It
25 is not in a cost booklet. It is all based on the list
26 price less the discount.

27 MR. MACLEOD: Do you ever on those occasions
28 resort to the price book put out by the Canadian Pharma-
29 ceutical Journal?

30 MR. ISAACSON: It is a very handy book



1 because it has all the drug items, front shop items as
2 well as dispensing items, and it is very quick and effi-
3 cient.

4 MR. MACLEOD: Do the manufacturers who
5 invoice you at net prices supply you with price lists
6 showing list prices?

7 MR. ISAACSON: There are catalogues each
8 firm puts out of all their products. As I say, they are
9 changing. They have been in the past showing the list
10 prices in the catalogue.

11 MR. MACLEOD: Yes. I want to ask you if
12 you agree with the Director's comments on page 248, para-
13 graph 444? Perhaps you could just glance quickly through
14 paragraph 444.

15 MR. ISAACSON: Yes, that is correct. Up
16 until now it has been the practice of the manufacturers
17 to show the prices as list, but they are changing it.
18 This is something that is entirely up to them, but the
19 manufacturers are beginning to issue price lists at the
20 net cost.

21 MR. MACLEOD: Or where there is an acceptance
22 by the trade as the list price as being the correct price
23 for a product.

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1 MR. ISAACSON: Yes.

2 MR. MACLEOD: Now, referring to the question
3 of generic drugs, do you stock any drugs under the generic
4 name simply because they are lower priced than comparative
5 brand name products?

6 MR. ISAACSON: No. We will stock any
7 product that the doctor orders, and if the doctor is
8 ordering certain brands, shall we call it, or lower priced
9 generic drugs, we would have them in stock.

10 MR. MACLEOD: Yes. So that you do not stock
11 any of these simply on the basis that you will have some-
12 thing you can offer to your customers at a lower price?

13 MR. ISAACSON: No.

14 MR. MACLEOD: Then if a generic manufacturer
15 comes to you and says he can give you a product that is
16 comparable to a certain brand name product at a cheaper
17 price, that has very little appeal to you?

18 MR. ISAACSON: Not just for the sake of
19 buying - first of all, I can't say that a firm coming in,
20 making that statement, it necessarily follows that the pro-
21 duct which he is selling is exactly the same quality as
22 some of the brands we have on the shelves.

23 To me I would want to be satisfied that
24 first of all the quality is there. However, primarily,
25 and again this is misleading, primarily first of all we
26 could not begin to stock all the different products which
27 suppliers sell of a similar drug. Therefore, we have to
28 maintain our dispensing stock according to the prescrip-
29 tions that come into the store.

30 MR. MACLEOD: Yes. My point was this:



1 whether or not, apart from any question of quality, the
2 lower price of a prescription drug is a selling point to
3 you?

4 MR. ISAACSON: Not just because of the
5 price.

6 MR. MACLEOD: Mr. Gilbert, in giving evi-
7 dence here yesterday, said it was something to this
8 effect, that it was useless for him to go to the druggists;
9 that he had to first get the doctor to prescribe his pro-
10 ducts.

11 MR. ISAACSON: Yes.

12 MR. MACLEOD: That would be precisely the
13 situation?

14 MR. ISAACSON: That is correct.

15 MR. MACLEOD: You made some mention of
16 certain drugs being reduced. Do you find that presently
17 there is an upward movement in the prices of the commoner
18 patent or proprietary products?

19 MR. ISAACSON: No.

20 MR. MACLEOD: One well-known headache
21 remedy has gone up 6¢ recently. Is that just an isolated
22 case?

23 MR. ISAACSON: I think so. There has been
24 very little - in fact if the question is put the other
25 way, there would be more likelihood of these items
26 coming down in price rather than going up.

27 MR. MACLEOD: Can you think of any parti-
28 cular proprietary or patent products that have dropped
29 drastically in the last year or two?

30 MR. ISAACSON: Without checking into it, I



1 could not recall.

2 MR. MACLEOD: What would your general
3 impression be, that the prices have been fairly stable?

4 MR. ISAACSON: I would say that.

5 THE CHAIRMAN: There are exceptions of
6 course, are there not?

7 MR. ISAACSON: Of increases?

8 THE CHAIRMAN: There have been increases
9 in some of the proprietary medicines?

10 MR. ISAACSON: Very few.

11 THE CHAIRMAN: Do you call Milk of Magnesia
12 a proprietary drug?

13 MR. ISAACSON: Yes.

14 THE CHAIRMAN: Has that gone up?

15 MR. ISAACSON: It has come down. Competition.

16 THE CHAIRMAN: The two brands I know of have
17 gone up in the last year.

18 MR. ISAACSON: A lot of cut pricing.

19 MR. MACLEOD: Do you or your pharmacists
20 make use of a code word for putting prices on prescrip-
21 tions?

22 MR. ISAACSON: On the prescription itself?

23 MR. MACLEOD: Yes, the use of the word pharma-
24 cist?

25 MR. ISAACSON: No, we put down just the
26 price. \$2.75, \$3.50, whatever the price is.

27 MR. FRAWLEY: \$9.70. Don't forget the high
28 ones when you are naming them off like that.

29 MR. ISAACSON: Well, 90% of our prescriptions
30 are in the lower price range. The use of the word



1 pharmacist, if you want an answer to that, or do you just
2 want to know what we do with our prescriptions?

3 MR. MACLEOD: What do you do with your
4 prescriptions?

5 MR. ISAACSON: We just put the regular
6 figures on them.

7 MR. MACLEOD: Do you mark that on the pres-
8 cripition if a customer merely passes it in to get you to
9 estimate the price?

10 MR. ISAACSON: It doesn't happen very often.
11 It is very seldom that happens actually in our stores.
12 The people don't come in and question prices. They come
13 in and bring in the prescription and want it filled. They
14 know our prices are reasonable. There is very little
15 question to the price of prescriptions.

16 MR. MACLEOD: If the customer asks you
17 for a copy of the prescription that you have filled, do you
18 indicate the price you charged in any way on the prescrip-
19 tion itself?

20 MR. ISAACSON: I would, yes.

21 MR. MACLEOD: You say you would, but is it
22 the practice in your stores to do that?

23 MR. ISAACSON: In our stores, yes.

24 MR. MACLEOD: You were going to express some
25 opinion about the use of the word pharmacist?

26 MR. ISAACSON: Pharmacost with an 'o'
27 instead of an 'i' is commonly used right across the United
28 States and Canada I think, and usually if the price is
29 put down - quite often it might not have been put down -
30 but if I were putting it down on a copy, I would put down



1 in that code what we charge for it.

2 MR. MACLEOD: Now, if you received a pres-
3 cription which had previously been coded by some other
4 druggist, do you charge the same price?

5 MR. ISAACSON: Again each one would have to
6 be taken on its merit. If the price was a normal price,
7 and that would apply whether it was in code or in regular
8 figure; if it was a proper price, we would charge the
9 same if we felt that is about what we would have charged
10 in the first place.

11 MR. MACLEOD: But you wouldn't feel any
12 obligation to follow that price?

13 MR. ISAACSON: Usually the prices are pretty
14 well general. There would be no need to question it.

15 MR. MACLEOD: What I am just trying to get
16 clear if I can, what the practice is in your stores. If
17 a prescription comes in which has a price on it, either in
18 code or in figures, do you normally honour that price?

19 MR. ISAACSON: If we receive a copy you mean
20 from someone else?

21 MR. MACLEOD: Yes.

22 MR. ISAACSON: Generally it would be honoured.

23 MR. MACLEOD: Now, the prescription pricing
24 guide I believe suggests a minimum fee for prescriptions;
25 that prescriptions be not filled at less than \$1.15. Is
26 that correct?

27 MR. ISAACSON: That is a minimum suggested.

28 MR. MACLEOD: In the operation of your
29 stores, do you observe this minimum?

30 MR. ISAACSON: Yes. Well, there are not



1 very many that go - the time you charge 75¢, 75¢ in that
2 \$1.15 is a dispensing fee, so the cost of the ingredients
3 and the container, whatever it is that is used to dispense,
4 is 40¢, then you can't get much below that any ingredients
5 that are being used.

6 It would not mean something is only going to
7 cost 1¢ and we are charging \$1.15 for it. Very seldom do
8 our prescriptions come down to that. There may be one in
9 - 2% or 3%, but not very many.

10 MR. MACLEOD: I realise all those factors,
11 but the point I wanted to get at was whether in fact you
12 do use the minimum in your work?

13 MR. ISBLISTER: He said yes.

14 MR. MACLEOD: You do?

15 MR. ISAACSON: Yes.

16 MR. MACLEOD: I think those are all the
17 points I have, sir.

18 MR. WHITELEY: Do you group the buying for
19 those stores in which you have a financial interest?

20 MR. ISAACSON: Not for dispensing items.

21 As a rule, each manager buys his own.

22 THE CHAIRMAN: Thank you very much, Mr.
23 Isaacson.

24 MR. ISBLISTER: I have nothing further to
25 add, Mr. Chairman.

26 MR. MACLEOD: May I raise one brief point
27 before we adjourn just so that it will appear on the
28 record? In the examination of Professor Dixon, Mr. Payton
29 said, as recorded on page 2087 of the transcript - this
30 is not very long to read it - "Mr. R.C. Payton: The only



1 reason I am on my feet is having at one time acted for
2 Fine Chemicals and having been many times in their plant,
3 it astounds me that my friend Mr. MacLeod seems to have
4 an intimate knowledge, or if I may say, a lack of intimate
5 knowledge of their processes which he is putting forward
6 as accurate information. I feel that the statement that
7 he is making is most misleading. I question whether he
8 can accurately inform you as to whether it is a packaging
9 operation or a manufacturing operation or just exactly
10 what the operation is", and that will serve to illustrate
11 my point.

12 The information which I gave to the Commis-
13 sion, the quotation from page 168 of the Green Book, is
14 the information supplied us by Fine Chemicals, and the
15 information was asked for in the form that does not leave
16 it open to any misconstruction; the information which I put
17 is accurate, and they are both costs of the comparable
18 product.

19 THE CHAIRMAN: You are quoting from replies
20 received from Fine Chemicals itself?

21 MR. MACLEOD: Yes. I want to put on the
22 record there is no possibility of the confusion that Mr.
23 Payton speaks of. The information I gave related to compa-
24 rable products, and were prices for drugs in the same
25 stage of manufacture.

26 THE CHAIRMAN: This will conclude the
27 hearings in Toronto. I point out the examination of one
28 witness, Mr. Dixon, has not been completed, and it has
29 been suggested that the Commission have a hearing in
30 Ottawa to wind up the hearings of the whole, and that



1 Mr. Dixon's examination be completed then, and that counsel
2 for any of the parties who desire to do so may then present
3 some summation of argument on what they think would be
4 useful for the purpose of concluding their presentation
5 to the Commission.

6 We have not fixed a final date because not
7 everybody is here who may be interested. I am not sure
8 whether Mr. Dixon can appear, but we have in mind tenta-
9 tively Tuesday morning, the 14th of November. If that
10 date proves to be satisfactory, that is the date on which
11 we will hold the final hearing in Ottawa.

12 The hearing is adjourned.

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14 --- Whereupon the hearing adjourned until Tuesday,
15 November, 14th, 1961 (tentatively).

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